THE INDIGENT CARE STUDY COMMISSION

REPORT TO THE

1989 GENERAL ASSEMBLY

OF NORTH CAROLINA

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NORTH CAROLINA GENERAL ASSEMBLY

January 12, 1989

TO: The Honorable Josephus Mavretic, Speaker of the House of Representatives,
The Honorable James Gardner, Lieutenant Governor,
The Honorable Henson Barnes, President Pro Tem of the Senate,
The Members of the General Assembly

Transmitted herewith is the final report of the Indigent Care Study Commission which was authorized by Chapter 738 of the 1987 Session Laws. The Commission was established to study the issue of health care access and financing for North Carolina's medically indigent citizens.

On behalf of the members of the Commission, we are pleased to present the Commission's recommendations to you, and to the 1989 General Assembly.

Respectfully Submitted,

Senator Tony Rand
Co-Chair, North Carolina Senate

Representative Walter Jones
Co-Chair, North Carolina House of Representatives

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PREFACE

The North Carolina General Assembly created the Indigent Care Study Commission in 1985 and again in 1987 to study the problem of medical indigency in North Carolina. The Commission consists of sixteen members with six members appointed by the Speaker of the House of Representatives, six members appointed by the President of the Senate, and two members appointed by the Governor. The legislation authorizing the Commission and a list of the membership and staff of the Commission are shown in Appendix A.

The 1987 Commission separated into two Subcommittees. The Subcommittee on Private Options was instructed to explore private sector solutions to the indigent care issue; the Subcommittee on Public Options was instructed to explore options for Governmental intervention. The membership of the respective subcommittees is shown in Appendix A.

The Subcommittee on Government Options held a total of five meetings. The Committee heard presentations from the staffs of the Department of Human Resources Divisions of Medical Assistance and Health Services. A list of persons appearing before the Subcommittee and of the reports presented to the Subcommittee is listed in Appendix B.

The Subcommittee on Private options held a total of four meeting and received testimony from the Department of Human Resources Office of Rural Health, the Duke Health Policy Project, The Health Care Trust Commission and representatives of the private sector. A list of persons appearing before the Subcommittee and of the reports presented to the Subcommittee is listed in Appendix C.

This report presents the recommendations of the Commission to the 1989 General Assembly. A summary of the 1987 General Assembly action on the previous Commission's recommendations may be found in Appendix A.

OVERVIEW

The problem of indigent health care is an issue which affects all North Carolinians -- not just poor individuals in a health crisis. Many individuals have no insurance coverage or insufficient coverage to meet their health care needs. As the cost of health care escalates and the state's population increases and ages, greater numbers of individuals and their families become medically indigent. As a consequence, hospitals and other health care providers bear an increasing burden for uncompensated care. This burden is passed on to those persons who can pay for service in the form of higher charges. Among communities with public hospitals, the cost of uncompensated care is passed on to the local taxpayer.

Throughout the Commission's study of medical indigency in North Carolina, Christopher J. Conover, Research Associate at the Center for Health Policy Research and Education at Duke University, provided the Commission with data analysis that documented the nature and scope of the indigency problem in North Carolina. The following document was prepared for the Commission by Mr. Conover and has been edited, with Mr. Conover's permission, for inclusion in this report. The Commission wishes to express its appreciation to Mr. Conover for his contributions to this report and for his assistance to the Commission throughout its study of medical indigency in North Carolina.

NORTH CAROLINA'S MEDICALLY INDIGENT

by
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WHO ARE THE MEDICALLY INDIGENT?

The medically indigent are people who cannot fully pay for needed health services on their own. For example, those who qualify for Medicaid are medically indigent, since this program is designed specifically to provide comprehensive health care to very low income people. But the medically indigent also include those who leave unpaid hospital and doctor bills and those who choose *not* to obtain needed health care because of inability to pay.

HOW MANY MEDICALLY INDIGENT ARE IN NORTH CAROLINA?

Each year, more than 400,000 people in North Carolina are served through Medicaid. In addition, among hospital patients in this state, nearly one third--roughly 300,000 per year--leave at least some portion of their hospital bill unpaid. Hospitals receive *no* reimbursement from any source for ten percent of their patients (roughly 100,000 patients annually). There also probably are at least 100,000 patients in our state who rely on free physician care. Finally, we estimate that as many as 125,000 North Carolina families elect not to obtain health care that they need--principally due to financial barriers to access.

These suggest the annual number of medically indigent is at least 750,000--one in every eight North Carolinians. But an even greater number are at *risk* of becoming medically indigent.

HOW MANY ARE AT RISK OF BECOMING MEDICALLY INDIGENT?

There are four major groups at risk of becoming medically indigent.

Financially Catastrophically Ill: nearly 300,000 people in North Carolina live in families who health expenses exceed 20 percent of their annual incomes. Two thirds of these families have incomes below poverty. Families faced with such high financial burdens clearly are at high risk of becoming medically indigent.

Medically Uninsurable: there are 50,000 individuals who cannot obtain health insurance because of medical conditions, such as those with diabetes, arthritis or other chronic conditions which result in predictably high medical costs. Insurers are reluctant to add such individuals to exiting insured groups since that would raise premium costs for everybody. But without insurance, such chronically ill individuals cannot always fully pay their medical expenses.

Uninsured: on an average day, there are nearly 900,000 people in North Carolina who have no form of health insurance. They do not qualify for public insurance such as Medicare (which covers the elderly and disabled) or Medicaid (which covers certain very low income people). The uninsured also do not have group health insurance from an employer nor can they afford to buy individual health insurance on their own. Because they have no insurance, such individuals must pay all medical bills out of pocket. In contrast, a typical person who is always insured pays less than one fourth of all medical bills out of pocket.

More than 400,000 of the uninsured have incomes below poverty. Excluding individuals who are not in families, the typical poverty family has three people. A family of three is considered poor if its annual income is under $9,300 a year. The average hospital stay in North Carolina now costs over $3,000. So a typical uninsured poor family faced with such a bill would either have to use up one third of its income to pay the hospital or leave all or part of the bill unpaid. This illustrates why the uninsured poor have the highest risk of becoming medically indigent.

Underinsured: on an average day, North Carolina may have as many as 750,000 people who are "underinsured." These individuals have insurance, but there are enough holes in their coverage that they still are at risk of spending more than 10 percent of annual income on health care. For example, there are more than one quarter million people in North Carolina who rely exclusively on Medicare to cover medical costs. Even with Medicare, average out-of-pocket expenses for the elderly amount to $2,700 a year. The majority of elderly live alone and the poverty level for individuals living alone is $5,500 a year. So for the 70,000 individuals below poverty who rely solely on Medicare coverage, expected out-of-pocket costs would equal nearly half of their annual income.

WHAT ARE THE CHARACTERISTICS OF THE MEDICALLY INDIGENT?

Fewer than half of the uninsured are poor, but many do have low incomes: nearly 80 percent of the uninsured in North Carolina have incomes below 200 percent of poverty. Most of the uninsured poor are young: nearly half are children and another one fourth are young adults under age 30. Over half are female and nearly half are black. Fewer than half of uninsured poor adults are married and a majority of uninsured poor children live without two parents.

Most of the uninsured poor are in working poor families. Nearly 40 percent are full-time workers or are dependents of full-time workers. Another one fifth are part-time workers or their dependents of the unemployed. The remaining one third are not in the labor force or are dependents of those not in the labor force: such individuals are housekeeping, retired, unable to work due to disability or are students. Thus, the medically indigent are a very heterogeneous group.

WHY ARE SO MANY PEOPLE AT RISK OF BECOMING MEDICALLY INDIGENT?

Nearly 40 percent of the poor in North Carolina are uninsured. There are two important factors accounting for this large fraction. First, each state sets its own Medicaid eligibility standards and ours is very restrictive. The income level used to determine eligibility is nearly 20 percent lower in North Carolina compared to other states. As a consequence, only about one fourth of our poverty population qualified for Medicaid, compared to 45 percent of the poor who qualify in other states. Since most of those covered through Medicaid are otherwise uninsured, the number of uninsured poor in North Carolina could nearly be cut in half if our eligibility standards merely matched the national average.

The second problem is lack of employer-provided coverage. Over half of the uninsured poor could be covered if all full-time or part-time employees and their dependents had health benefits. Roughly half of the uninsured who could be covered by an employer work for small firms (under 20 employees). The cost of health insurance can be as much as 30 to 50 percent higher for small firms compared to large firms, so they are more reluctant to purchase coverage for their employees. The solution for uninsured workers in small firms is to make coverage more affordable so that more employers offer plans.

For the remaining uninsured workers in large firms, the problem is much different. Three-fourths of the uninsured in larger firms work for employers who already offer health plans. The problem is that many of these plans contain restrictions that make newly hired workers, part-time, and seasonal employees ineligible. Waiting period requirements alone may account for nearly half of all uninsured workers who are employed in firms that already have health plans. Therefore, the solution for uninsured workers in large firms is to find ways of removing these restrictions.

WHY IS INDIGENT HEALTH CARE AN INCREASINGLY SERIOUS PROBLEM?

Between 1980 and 1985, the number of uninsured poor in North Carolina increased by more than 50 percent. Less than one third of this growth occurred because the number of people in poverty has grown; most of the rise happened because the likelihood of being uninsured has risen among the poor. For example, the latest data for North Carolina show that on an average day, over half of all children below poverty are uninsured.

This increase in the uninsured poor means there are more people with unpaid bills and this has increased the burden on state and local government. For example, state appropriations to teaching hospitals--much of which is used to offset the cost of indigent care--increased 13 percent a year between 1984 and 1986. Direct payments by county and local government for indigent care increased 9 percent a year between

1985 and 1986. These rapid increases occurred at a time when the general inflation rate was below 5 percent a year.

But the increasing burden on government is only half of the problem. Outside revenues, including state and local payments to hospitals, only coverage about one half of the cost of providing hospital care to patients who leave unpaid bills. Traditionally, hospitals have financed the remaining cost of indigent care through "cost shifting". By charging privately insured patients higher hospital rates, hospitals were able to cover unpaid bills without incurring deficits.

However, with increased price competition in the hospital industry, the ability to shift costs decreased each year. Private payeers are increasingly sensitive to differences in prices between competing hospitals. This puts hospitals with disproportionately high indigent care loads at a competitive disadvantage. If they raise rates to cover their indigent costs, they risk losing private patients. But if they charge competitive rates, they may not raise enough revenue to cover their indigent costs. In either case, financial deficits may result that cannot be sustained over the long term. National data show that hospitals tuck in this dilemma often choose to cut back on their care to the indigent rather than incur chronic deficits. When this occurs, it leads to serious problems of access for indigent patients.

HOW DO THE MEDICALLY INDIGENT OBTAIN MEDICAL CARE?

Compared to the general population, the uninsured poor are somewhat sicker (they are healthier than those on Medicaid, but this is not surprising since many Medicaid recipients qualify because they have high medical bills that result from their being sicker than average). Yet the uninsured poor–particularly those with insurance for the entire year--use far fewer health services. The annual number of hospital days and physician visits is 30 to 50 percent less among the uninsured poor compared to poor people in similar health who have insurance.

For the most part, these limitations on access appear self- imposed. Roughly three percent of uninsured adults report being refused care by a provider, while nearly 90 percent report *no* problems in getting medical care. For those reporting difficulties in access, cost is the major barrier, and it often leads to decisions to defer non-urgent care. For example, those without insurance are less likely to obtain elective surgery or to use high technology medical procedures such as coronary bypasses. Most hospital care that is uncompensated is related to either pregnancies or accidents--which by their nature cannot be deferred.

When they need a doctor's care, the uninsured poor are more likely to use local health departments, community health centers, or hospital emergency rooms as their regular source of care. Nevertheless, despite their limited ability to pay, a majority use private physicians as their main source of care. In short, the uninsured and uninsured poor do have some access to the existing system, but their limited ability to pay often leads them to choose less care than if they had insurance.

WOULD BETTER ACCESS IMPROVE HEALTH OF THE MEDICALLY INDIGENT?

The available evidence suggests that better access would lead to improved health status among the medically indigent. For example, it is well known that early prenatal care substantially reduces the risk of low birthweight babies and all their attendant health problems and costs. Yet each year in North Carolina, nearly 1,000 women deliver babies without any prenatal care whatsoever.

Similarly, the cancer survival rate for those with high socioeconomic status is 10 to 15 percent better than for those with low socioeconomic status. At least half of this difference is due to late diagnosis of cancer, which can occur when low income patients elect to defer regular medical check-ups.

Finally, a national experiment on health insurance showed that low income patients with high blood pressure who obtained free care had better health than similar patients whose health insurance plans required them to pay part of their medical bills out of pocket. These various findings support the idea that health status could be improved for the medically indigent through better access, even if it is difficult to estimate with precision how much of an improvement would occur.

HOW LARGE IS THE ECONOMIC BURDEN OF INDIGENT?

In 1985, $1.2 billion was spent in North Carolina to subsidize medical care for those who did not fully pay their medical bills. This amount equals nearly 20 percent of all health care spending in the state for that year.

The total includes more than $300 million spent through Medicaid and excludes another $300 million in Medicaid costs for nursing homes. It also includes nearly $500 million for various public programs, such as VA medical care, care provided through local health departments, public health clinics and community mental health centers. Surprisingly, only about one fifth of the total is accounted for by hospital bad debts and charity care and the remainder consists of unreimbursed care provided by physicians.

Even more surprising is that even when Medicaid is excluded, over half (56%) of all subsidized care goes to persons *with* insurance. Only 28 percent of all subsidized care is accounted for by the uninsured poor and the remainder is for the uninsured above poverty. So even if a way could be found to provide coverage for all uninsured people in North Carolina, more than half of the economic burden of medical indigency would remain.

WHO PAYS FOR INDIGENT HEALTH CARE?

Over half of the $1.2 billion is paid by the federal government and therefore poses little tax burden on North Carolina citizens. More than $200 million is paid by state government and an additional $72 million is paid through county or city government. Private sources, including cost-shifting to private patients as well as philanthropy, account for less than one fourth of the subsidized care total.

Of the amounts paid directly by North Carolina citizens, the average burden per person for families above 200 percent of poverty is $120 a year. Thus, a family of four in this income category absorbs roughly $500 a year in costs associated with care for the medically indigent. The per capita burden of indigent health care for poor and near poor families ranges from roughly $30 to $50 a year, depending on income category.

In absolute terms, those with high incomes pay more than those with low incomes. But if this burden is computed as a percent of family income, the burden of paying for the health needs of others is twice as large for families in poverty compared to those above 200 percent of poverty.

IS THE BURDEN OF INDIGENT HEALTH CARE EVENLY DISTRIBUTED?

Aside from the regressive burden on individual families, there are many other inequities in the current patchwork system of paying for indigent health care in North Carolina.

Among hospitals, for example, the burden sometimes is shared unevenly. In 1982, the average charges for private pay patients would have had to be set 10 percent higher in order to completely cover the costs of charity care and bad debts which were not offset by other revenue sources (such as public funds). But in some hospitals, this potential add-on to private patient costs was as high as 40 to 60 percent, whereas in other hospitals it was zero. In absolute dollars, the potential add-on for the average private patient was $28 per day. But again, in some facilities this potential add-on could have exceeded $100 per day.

Similar problems face doctors. Nationally, doctors must raise their charges to private patients by five to 15 percent to cover their uncompensated care costs. But this average masks sharp differences between doctors. For example, only half of North Carolina doctors accept Medicaid patients and the majority of such patients are cared for by a small fraction of physicians. Similar disparities almost certainly exist in care for the uninsured poor. In one North Carolina county, there are only 40 uninsured poor per primary care physician, whereas in another county the number exceeds 1,000 uninsured poor per physician. Such large differentials mean that in the latter county, either medically indigent patients face greater barriers to access *or* physicians have a substantially greater burden of providing free care compared to their counterparts in the former county.

On average, local taxes for subsidized health care amount to $19 per resident. But this ranges from as low as $7.50 per resident in one county to roughly $150 per resident in another.

All of the above disparities raise serious questions about whether the burden of paying for care of the medically indigent is equitably disturbed.

WHO IS RESPONSIBLE FOR INDIGENT HEALTH CARE?

North Carolina is one of only three states which does not explicitly identify how responsibility for indigent care is to be divided between the state and counties. Even though it does not have either a constitutional

or statutory requirement to serve as payor of last resort, historically the state has provided funds to the two major public teaching hospitals to cover both teaching and indigent care costs. These appropriations to N.C. Memorial Hospital and Pitt County Memorial Hospital amounted to $31 million in 1986.

State law does require that counties with county-owned hospitals provide indigent care. However, only 47 of our 100 counties own a hospital and 11 of these 47 counties do not appropriate any funds to their hospitals for indigent care. At the same time, many other counties make indigent care appropriations even though they are not legally liable to do so. In 1986, counties and cities spent $36 million on indigent-related hospital funding.

Hospitals which in the past have received federal Hill-Burton funds for construction or renovation are required to provide a certain amount of charity care each year. These obligations amounted to $21 million in 1985.

New federal legislation requires that hospitals which receive Medicare funds (virtually all hospitals do) must render emergency care to all patients in need regardless of ability to pay. They may not transfer such patients except after they are in stable medical condition and the receiving facility has been notified. Moreover, hospitals are not permitted to transfer such patients solely because of inability to pay: they must demonstrate that they do not have the proper facilities to care for that patient.

In contrast to the various obligations imposed on hospitals, physicians legally and ethically are free to choose whom they will serve. The American Medical Association's Principles of Medical Ethics explicitly allows physicians to refuse treatment to any patient even if no other physician is available. Roughly half of North Carolina physicians do not accept Medicaid patients and North Carolina figures suggest that provider refuse to provide care to at least 30,000 patients a year--of which two thirds have no insurance.

WHAT ARE THE OPTIONS FOR DEALING WITH MEDICALLY INDIGENT?

At the state level, there is no single solution to the problem of medical indigency. Different strategies are suitable for addressing different pieces of the problem. A comprehensive solution therefore requires a mix of strategies.

There are five broad strategies to consider. The first is to **expand Medicaid**, since the federal government will pay for two- thirds of Medicaid costs in North Carolina. Maximum allowable expansion of Medicaid could cover nearly three-fourths of the uninsured poor population (the remainder can never qualify for Medicaid because they do not fall into any of the Medicaid coverage categories--aged, blind, disabled, dependent children under age 21, single parents, or adults in families with an unemployed breadwinner). The recommendations recently approved by the Indigent Health Care Study Commission probably will reduce the uninsured poor population by 42 percent once they are fully implemented.

For those who are not reached by Medicaid expansion, the second strategy is to **expand employer-based coverage**. This approach could reach nearly half of the uninsured poor who can never qualify for Medicaid.

Those who cannot be assisted using the first two approaches might be helped by the third strategy: **expand individual coverage**. This approach may be particularly useful for certain groups such as the medically uninsurable and those with catastrophic medical bills.

Regardless of how much insurance coverage is extended, there will always be some who otherwise fall between the cracks. They will have to rely on the vast array of different publicly financed health programs available through local health departments, community health centers or the community mental health system. A fourth approach is to **strengthen the public safety net** to ensure that these programs are accessible and can effectively meet the health needs of those who rely on them.

Finally, steps can be taken to **level the health care playing field**. This would involve smoothing out some of the inequities in how we now pay for indigent health care.

In short, there is much that can be done, but the problem cannot be eliminated quickly, easily or cheaply. If the problem were not complex, it would have been solved a long time ago. Instead, it is a long term problem that cannot be solved in a single year or even a biennium. It is not a simple problem susceptible to simple solutions. A viable long term strategy must be crafted with care and the temptation to latch onto

band- aid solutions should be avoided. The problem also is sufficiently large that it is unlikely that either the public or private sector working alone can resolve the problem. Instead, a viable long term approach almost certainly will require a sustained partnership between the public and private sector in the years ahead.

EXPAND MEDICAID

Due to very tight eligibility rules, less than one third of North Carolina's poor enroll in Medicaid each year. For those who do qualify, Medicaid provides good benefits: unlimited hospital care and extensive coverage for physician visits, prescription drugs, lab and X-ray services and dental care. However, eligibility is restricted to the very poorest individuals: current income eligibility levels are set at roughly 35 to 45 percent of poverty, depending on family size. North Carolina does have a "spend-down" provision, meaning that medical bills can be subtracted from income to determine eligibility. Thus, even people with incomes above poverty can qualify if they have high medical bill. As a consequence, nearly one fourth of Medicaid eligibles have incomes above poverty—but these individuals may have had to spend 50 percent or more of their income to qualify.

There are two ways to expand Medicaid: by adjusting income eligibility standards, or by increasing outreach efforts.

ADJUST INCOME ELIGIBILITY STANDARDS: there are a number of options for increasing the income thresholds use to determine Medicaid eligibility.

Expand Coverage For Elderly & Disabled: there are two major options for increasing coverage to this group.

All Elderly/Disabled Up to Poverty: states may elect to cover all elderly and disabled up to any income threshold that does not exceed federal poverty guidelines (resource standards may be no more restrictive than those used in SSI). However, to exercise this option, the state must also cover all pregnant women and infants up to the same income level. The study commission has recommended covering all aged, blind and disabled up to 75 percent of poverty.

SSI Recipients—the current Medicaid program only covers I recipients with the lowest incomes and/or greatest medical expenses. The state could elect to automatically cover all aged, blind and disabled persons who receive Supplemental Security Income (SSI). 36 states have adopted this approach. The Study Commission has recommended this approach.

Expand Coverage For Families

Pregnant Women and Infants: In keeping with the 1986 Indigent Care Study Commission recommendation, the 1987 General Assembly authorized coverage of pregnant women and infants under age 1 whose family incomes fall below 100% of the federal poverty level. Subsequent federal legislation (The 1987 Omnibus Reconciliation Bill) permitted states to cover all pregnant women and infants up to 185% of the federal poverty level. The Study Commission could endorse this federal option to improve coverage for pregnant women.

Young Children: In keeping with the recommendations of the 1986 Study Commission, the General Assembly authorized phased in coverage of children under age 5 whose family incomes fall within 100% of the federal poverty level. Under the federally mandated phase in schedule, children under age 3 were covered over the 87-89 biennium; children under age 5 will be covered over the 89-91 biennium. Subsequent federal legislation (the 1987 Omnibus Reconciliation Bill) permits children born after September 30, 1983 to qualify immediately. The Commission could endorse accelerated and expanded coverage for this group of children.

Increase AFDC Payment Standards: to expand the number of eligibles in all categories, the state could elect to increase the AFDC payment standards. States are permitted to set their AFDC payment standard at any level. These cash payment levels are of critical importance in determining how many qualify for Medicaid because under federal regulations, the medically needy income level cannot be more than one third higher than the

AFDC payment standard. Currently, North Carolina's medically needy income level is among the ten lowest in the nation. Despite recent increases in the standards, they have not kept pace with inflation. For example, in 1975, the AFDC payment standard for a family of 3 was roughly 52 percent of federal poverty guidelines, yet by 1986 it had dropped to 33 percent of poverty. The study commission recommended gradually increasing the medically needy income level to 75 of poverty, which would require raising the AFDC payment standard to 56 percent of poverty.

INCREASE OUTREACH EFFORTS: On an average day, there may be 50,000 to 215,000 persons in North Carolina who are technically eligible to participate in Medicaid, but who decline to enroll. There are many different reasons that people have for not enrolling: lack of information and the stigma attached to "welfare" are among the most important reasons. If such individuals are hospitalized and cannot pay their bills, hospitals are likely to encourage them to apply for Medicaid benefits (which can retroactively pay for care obtained as much as three months earlier). Thus, such individuals are not likely to contribute heavily to the hospital uncompensated care problem. But if lack of health coverage leads such individuals to do without needed care such as physician services or prescription drugs, they may put themselves at higher risk of unneeded inpatient care.

Recent changes in federal law directs states to increase their outreach efforts for pregnant women. The study commission endorsed such outreach efforts on behalf of pregnant women.

LIMITATIONS OF EXPANDING MEDICAID: If all of the study commission recommendations are adopted, it would decrease the number of uninsured poor by more than 40 percent. However, there still would remain roughly 59,000 uninsured poor who are eligible for Medicaid but are not participating and 64,000 uninsured poor who could be covered only if the legislature takes future steps to expand eligibility. There would also remain 114,000 uninsured poor who could never be covered by Medicaid—even if they had no income. This group consists entirely of non-disabled adults without children. Nearly 40 percent of these are single persons without children, while the remainder are married and living with a spouse.

In addition, there are nearly 300,000 uninsured persons who are "near poor" (having incomes between 100% and 200% of poverty). Therefore, even the maximum possible expansion of Medicaid would leave more than one half million poor and near poor North Carolinians without health insurance coverage. Medicaid expansion clearly falls short of solving the entire problem of medical indigency.

EXPAND EMPLOYER-BASED COVERAGE

In North Carolina, over one half of the uninsured poor are either working full or part-time or are dependents of family workers. If all full-time workers and their dependents were given health benefits by their employers, this would reduce the number of uninsured poor by nearly 40 percent. At higher income levels, the situation is even better: two-thirds of all uninsured persons above poverty live in families where one or more parents is working full-time (310,000 individuals).

Most workers do not have health insurance because they are not offered coverage—not because they have chosen to go without health insurance (nationally, only 11 percent of uninsured workers have refused coverage offered by their employer, perhaps because the employee share of premiums is too high). Workers without health insurance fall into two categories. Less than half of such workers are employed by firms which offer no health plan to any employees. The remainder are employees who may not qualify for the plan being offered by their company—either because they are new on the job or they are part-time or seasonal workers.

Workers in small firms (under 20 employees) are much less likely than workers in larger firms to be offered health benefits. More than three-fourths of uncovered workers in small companies work for employers who offer no health plan whatsoever. Thus, the most effective approach to getting coverage to such workers is to get more small employers to offer health benefits. In contrast, nearly 80 percent of uncovered workers in large firms work for employers who already offer a health plan. Therefore, the most effective approach to getting coverage to such workers is to get more large employers to relax restrictions on eligibility (e.g., by reducing waiting period requirements or allowing coverage for workers not employed full-time).

There are two major approaches to expanding group coverage through employers: by making such coverage more affordable or through regulation.

MAKE COVERAGE MORE AFFORDABLE

Assist Small Employers: small employers are substantially more likely than large employers not to offer health insurance to their employees. In North Carolina, roughly 40 percent of the uninsured who are employed work for small firms with fewer than 20 employees. Small employers are often inhibited from providing coverage due to the high cost. Because there are fewer employees over which to spread fixed administrative costs such as marketing, and because small employer with the sickest employees are much more likely to purchase such benefits, the premium cost for a given package of benefits might be up to 30 to 50 percent higher for small firms compared to large firms.

Encourage MET Development—One major option for reducing premiums is to organize small employers into multiple-employer trusts (METs). METs reduce costs by centralizing administration, but they also allow the possibility of obtaining price discounts from hospitals or other providers. The Health Care Trust Commission, which was created by the 1987 General Assembly on the recommendation of the 1986 Indigent Care Study Commission is exploring ways in which the state could encourage MET development.

Several other states are encouraging the creation of METs for small employers (Florida, Oregon, Tennessee, Utah and West Virginia). Florida is creating a state- sponsored MET that would be made available only to employers who had not offered health benefits for at least one year (this would discourage firms from dropping their current coverage). Since such coverage would be offered to people who previously were uninsured (who account for a disproportionate share of bad debt and charity care) the state might be able to negotiate deep discounts with providers and/or negotiate managed care arrangements. Blue Cross/Blue Shield of Western Pennsylvania successfully offered such a restricted plan to unemployed persons. Costs were kept low because providers were willing to discount normal fees and because recipients were willing to restrict their choice of providers.

Encourage Managed Care Arrangements—several states (Maine, Michigan, and Washington) are developed managed care plans, either in conjunction with MET development or as an alternative plan to be made available to those who cannot qualify for Medicaid or employer-based coverage. Efforts to cover small employers through HMOs also have been successful in lowering costs in Oregon and California.

Tax Credits for Health Insurance: even with all of the above cost reduction measures in place, some employer may continue not to offer health benefits to their workers, however. To further reduce premium costs, the state might use tax credits to offset some fraction of the cost of health coverage in firms not now offering benefits. Eligibility criteria would have to be carefully drawn in order to avoid encouraging new firms to delay offering benefits for some period (e.g., one year) in order to take advantage of generous premium subsidies. The limited information available on how firms would respond to such subsidies shows that even if tax credits reduce premiums by a large amount (e.g., 30 percent), the fraction of companies without plans who would offer plans in response to the tax credits may be fairly small (e.g., under 20 percent.

EXPAND GROUP COVERAGE THROUGH REGULATION

Mandate Group Coverage: a Federal law (ERISA) currently prohibits states from requiring that employers provide health benefits. Only one state (Hawaii) mandates health coverage, because it obtained a special federal exemption from ERISA. One possible way around ERISA is to tax employers(e.g., a franchise tax surcharge of $500 or $600 per employee or a tax on gross wages of 5 percent—whatever amount is needed to provide reasonably good coverage for that employee). Any employers which provide health benefits could receive a credit against the surcharge: thus, employers with adequate health coverage would pay no tax. Employers could elect to pay the tax instead of providing health benefits, in which case the state could pool the money to offer subsidized coverage to employees who had no benefits.

Regulate Group Health Plans: for companies which already offer health coverage, another possibility is to regulate eligibility requirements.

Reduce Eligibility Waiting Periods—nationally, roughly two-thirds of employers impose a waiting period before employees are eligible for health benefits, with 9 percent requiring a wait of 4 months or longer. This time lag forces employees to either do without coverage or pay out of pocket to continue benefits from a previous employer, which low income workers may find particularly difficult to do. North Carolina Citizens Survey data suggest that roughly 70,000 uninsured workers lack coverage because of such waiting requirements. To address this problem, the state could establish an upper limit on such waiting periods. However, ERISA would allow many large firms (which tend to have the longest waiting periods) to be exempt if they were self-insured. Since roughly one fourth of all health benefits are provided through self-insured employers in North Carolina, a sizable fraction of those 70,000 could not be assisted by state regulation of waiting period requirements.

Extend Continuation and Conversion Privileges—since July, 1986 federal law requires that all employers allow different categories of persons (e.g., divorced spouses) who have lost their group coverage the right to continue such coverage at group rates if they are willing to pay the premium out of pocket. Employers can charge no more than 102 percent of the regular premium rate to those who elect to continue their coverage, and they may keep their coverage from 18 months to three years, depending on their category (small employers with under 20 employees are exempt from these requirements). Prior to this federal change, North Carolina employers were subject to a state statute which extended continuation/conversion privileges for a period of only three months.

EXPAND COVERAGE FOR INDIVIDUALS

THE MEDICALLY UNINSURABLE

There are roughly 50,000 "medically uninsurable" people in North Carolina who are unable to obtain insurance because of chronic health conditions such as diabetes or epilepsy. To date, nine states have assisted the medically uninsurable by creating insured risk pools (Connecticut, Florida, Indiana, Minnesota, Montana, North Dakota, Rhode Island and Wisconsin). Under these pools, health insurers are required to offer qualified policies to certain categories of individuals (nearly all of these states stipulate that an individual must have been turned down twice before being eligible to purchase such policies). A cap is usually set on the premiums that can be charged— usually ranging from 125 to 150 percent of the premium that the individual normally would pay for non-group coverage.

If the pool loses money, they are shared equitably among participating insurers. However, in all but two states, the state directly or indirectly subsidizes the pools (e.g., by allowing insurers to credit their assessments dollar-for-dollar against their premium tax liability). One problem with pools is that ERISA does not permit self-insured plans to be assessed, so that larger employers can avoid paying an equitable share of pool loses. As more employers turn to self- funding, this shrinks the base of conventional coverage over which losses can be spread.

In 1986, the U.S. House approved a bill that would require each state to establish a risk pool for the medically uninsurable (beginning January 1, 1988). Such pools would have to offer coverage (typical of that offered by large employers) to any individual regardless of health status. Such individuals would pay premiums that could not exceed 150 percent of the average premium for non-group coverage in that state. All employers with 20 or more employers (including those with self-funded plans) would have to contribute to the pool to absorb any losses that result; those failing to do so would be taxed at 5 percent of gross wages.

Blue Cross and Blue Shield of North Carolina recently created a plan for the medically uninsurable—restricting it to individuals who have been refused health insurance at least twice by other private carriers. The premium equals roughly 167 percent of the average premium for non-group enrollees. Only a few thousand people have enrolled in the plan, mirroring the relatively small participation rates experienced by risk pools in other states. The chief drawback to risk pools is that they assist only those uninsured who

can afford the premiums. Except for Connecticut, states with pools have managed to enroll a mere fraction of the estimated number of uninsurables in their state. Such pools therefore really addresses only a small part of the indigent care problem.

FINANCIALLY CATASTROPHICALLY ILL

Each year, nearly 300,000 people in North Carolina spend more than 20% of their income on health. Of these, two-thirds have incomes below poverty so if more basic coverage is made available to the poor, the size of the financially catastrophically ill population diminish. Moreover, the Federal Catastrophic Health Care Act of 1987 mandates the Medicaid Program pay Part B premiums, deductibles and copaypments for Medicare beneficiaries with incomes below the poverty level. Beginning January 1988, Medicare beneficiaries with incomes below 80% of the poverty level will qualify. Thereafter, beneficiaries with incomes at 85%, 90%, 95%, and 100% will be phased in over a four year period. By 1992, all MediCARE beneficiaries with incomes below the poverty level will qualify for this Medicaid benefit.

There are some serious limitations to this plan, however. For example, the cap on out-of-pocket expenditures does not apply to nursing home care, even though they account for a large fraction of catastrophic illness experienced by the elderly. In addition, only one third of families with health costs over 20 percent of income are headed by persons age 65 or older. At best, therefore, the administration proposal would assist only a fraction of the 300,000 who have catastrophic health bills.

There are three way to expand catastrophic coverage. First, the state could mandate that *employers* who offer health benefits be required to include a maximum on out-of-pocket costs to employees (many plans limit out-of-pocket costs to $1,000 or $5,000, after which the plan pays 100 percent of subsequent costs). Second, the state could mandate that all *individuals* have a certain level of catastrophic protection, just as it now does on a much smaller scale in the case of automobile liability insurance. The third approach now in operation in three states (Alaska, Maine and Rhode Island) is a state-run catastrophic plan. Such plans generally require that patients meet relatively steep deductibles (e.g., out-of-pocket health bills in excess of 20 to 50 percent of income) after which the plan pays a large fraction (or all) of subsequent medical bills. As with risk-sharing pools, these state-run plans have tended to assist relatively low numbers of people, in part because deductibles are so high. The study commission has not yet determined whether to recommend any sort of catastrophic plan in North Carolina.

OTHER INDIVIDUALS NEEDING COVERAGE

Even with large increases in the number of individuals covered through Medicaid and employer-based coverage, there still will remain a sizable fraction of the uninsured population that remains uncovered. There are two major options for assisting such individuals.

State Health Insurance Pool: The AMA has endorsed the establishment of statewide pools open to anyone who cannot obtain group coverage, but Connecticut is the only state with a pool that is open to anyone— regardless of medical insurability. Missouri, Washington and Wisconsin all are considering state health insurance programs to cover those who cannot obtain coverage elsewhere. In addition, Wisconsin is opening its high-risk pool for medically uninsurables to allow sick and disabled employees from small firms to enroll, thereby reducing the cost of coverage for small employers.

The chief limitation of pools is that they can assist only those who can afford the premiums. A typical health plan costs at least $700 for an adult and $2,000 for a family. Since only 20 percent of North Carolina's uninsured have incomes above 200 percent of poverty, it is unclear how many uninsured would choose coverage in a statewide pool.

Tax Credits/Vouchers: Another option for expanding individual coverage entails giving all low-income individuals a tax credit or voucher which can be used to purchase a qualified health plan. The amount of the voucher would depend on family income and individuals could pay additional amounts out-of- pocket to obtain better coverage if desired. Unlike a catastrophic plan, which would merely put a ceiling on how much families pay out-of-pocket, a voucher plan could be used to ensure that all citizens have the means to purchase at least an essential minimum level of coverage. Vouchers also would be designed to stimulate competition among providers and to allow the medically indigent full access to mainstream medicine rather than the two-tiered system. This approach has been tried in some local

areas—notably in Multnomah County, Oregon—however, no statewide voucher plan has ever been attempted. Wisconsin is designing a state voucher system and Missouri is considering a state health insurance plan in which the premium amounts would be related to family income.

STRENGTHEN PUBLIC SAFETY NET

Given fiscal realities, it is likely that there will always be a number of persons who are either uninsured or underinsured and who otherwise would fall through the cracks if public programs were not available to provide essential health services. There are several different ways in which the current safety net of publicly provided health services can be strengthened. The study commission has not yet addressed any of these options.

STREAMLINE CURRENT PUBLIC MEDICAL PROGRAMS

There are over thirty different health programs in North Carolina which provide direct health services to the medically indigent. Income eligibility criteria are quite diverse: the threshold below which individual can obtain free care ranges from 40 percent of poverty in one program to 185 percent of poverty in several others. Also, many programs allow counties to establish eligibility criteria so that an individual eligible for services in one county might be ineligible in another. In contrast, of the 34 states with a state indigent care program, over three fourths establish statewide eligibility standards to ensure uniformity.

Although the federal shift towards block grant funding gives states great leeway in how they pool and spend health dollars, North Carolina's programs continue to be relatively categorical in focus. That is, they target very specific diseases, types of services, or categories of patients (e.g., some programs allow screening, but not treatment; others allow inpatient care, but not prevention). This inhibits the ability of local health departments to effectively target resources. Instead of being able to treat a full range of health problems within a particular target group, the state generally can assist only if that individual happens to have a disease covered by a state program. To improve access to publicly-provided health services, the state could elect to consolidate and streamline the programs now available.

CLARIFY PUBLIC SECTOR ROLE AND RESPONSIBILITY

North Carolina is one of only three states nationally which does not explicitly identify how responsibility for indigent care is to be divided between the state and counties. In North Carolina, counties are responsible for some level of indigent care only if they own a hospital. Since only 47 counties own hospitals, this leaves more than half which are completely exempt from responsibility. As a result, there are large differences across counties in the amount of publicly subsidized health care that is available to the medically indigent. The tax burden on local residents to finance indigent health care also varies substantially across counties—ranging from $7.50 per resident to as high as $150 per resident. Several states, such as Texas and California, have taken steps recently to clarify county responsibility for indigent care and given counties powers to discharge those responsibilities. Other states explicitly require counties to be financially liable for unpaid hospital bills of patients who cross county lines for care.

STATE INDIGENT CARE PROGRAM

34 states have some sort of statewide indigent care program (other than the multiplicity of federally-funded programs available in North Carolina). The range of benefits varies, but in nearly 75 percent of these states, the program covers both hospital and ambulatory services (often with limitations). In 16 states, the benefits are reasonably comprehensive, covering all services mandated under Medicaid. All told, 29 states have "state-only" Medicaid programs that cover individuals who are categorically ineligible for Medicaid, using 100% state dollars. Such programs are administered through Medicaid, thereby taking advantage of economies of scale in eligibility determination, claims processing, or other administrative functions. Such programs can be targeted at any group desired (e.g., chronically ill, non-elderly adults) and can cover any range of services.

22 states provide medical services through their state or county general assistance program. In most of these states, anyone qualified for general assistance may obtain medical benefits. The benefits range from

one-time emergency payments for urgent medical service to regular payments for health services. 8 states offer optional state assistance to counties or munici- palities which elect to provide indigent health care; the state matching rate may be as high as 75 percent.

LEVEL HEALTH CARE PLAYING FIELD

Short of universal health coverage for all persons, no expansion in coverage for individuals will completely eliminate the financial burden posed by the medically indigent, and there is no guarantee that the remaining burden will be evenly distributed. There are four basic options for improving the distribution of the burden and four ensuring access to those who continue to lack basic health coverage.

LEVEL FINANCIAL BURDEN ACROSS HOSPITALS

In 1985, North Carolina hospitals wrote off roughly $242 million in charges due to either charity or bad debts. Taking into account the actual costs of providing this amount of care, and deducting revenues (such as tax appropriations) that were used to offset these losses, roughly $57 million of this total was probably paid through "cost-shifting" to private patients. That is, the average private patient pays roughly $120 extra per hospital to pay for those who cannot fully pay their own hospital costs.

The amount of this "private tax" levied on private patients varies considerably across hospitals. However, currently the cost differentials in North Carolina are relatively small compared to states such as Florida and Virginia. Nevertheless, they illustrate that cost-shifting could come to be a serious problem in the future as employers become increasingly price-sensitive, hospitals with high uncompensated care loads may seek to lower their exposure to medically indigent patients (e.g., through imposing pre-admission deposits, etc.). There are three ways of ensuring that the burden of indigent care is equitably apportioned across hospitals.

Establish Hospital "Fair Share" Norms. Hospitals might voluntarily agree to provide a "fair share" of uncompensated care; for example, Kentucky hospitals have agreed to provide at least as much indigent care (defined as all charity care plus 40 percent of bad debts as a percent of total revenues) and Medicaid care (as a percent of patient days), as other hospitals in their local region. Alternatively, the state could use its regulatory authority to establish such norms. It might link approval of tax exempt bonds (which has not yet been tried anywhere) or Certificate of Need approvals to a commitment to provide some minimum level of charity care (4 states and the District of Columbia have adopted the latter approach). California uses an incentive approach, exempting projects from CON if facilities agree to provide over a five year period an amount of charity care equal to the dollar value of the project. Georgia requires that parties which purchase or lease public hospitals provide charity care equal to 3 percent of gross revenues.

Hospital Pool. Several states have created hospital pools financed either through a tax on hospitals, insurance premiums or other sources (Florida, New Jersey, New York and South Carolina). In New York and New Jersey, pool income is redistributed in order to more evenly distribute the burden of uncompensated care across hospitals. In Florida, pool revenues were used to finance Medicaid expansion and the creation of an outpatient care program. In South Carolina, the hospital tax funds are pooled into a fund that serves as payor of last resort to cover unpaid hospital bills for low income patients.

A number of other states, including Kentucky and Ohio, have examined "care or share" arrangements which generally would operate on a local basis. Under these programs, hospitals with low levels of indigent care contribute funds to a pool that is used to help offset the costs of indigent care in high-load hospitals.

Hospital Rate-Setting. Nine states have or are creating hospital rate-setting programs which have specific provisions for uncompensated care (Connecticut, Maine, Massachusetts, Maryland, New Jersey, New York, Washington, West Virginia and Wisconsin). In most cases, rate-setting explicitly allows a markup for uncompensated care to be built into approved rates. To the extent that all payers pay the same rate, the burden of uncompensated care is distributed relatively evenly across payors (but not necessarily across hospitals). In New York and New Jersey, the burden is more evenly distributed across hospitals through use of pools which reimburse hospitals with higher-than-average indigent care loads.

ASSIST FINANCIALLY DISTRESSED HOSPITALS

Aside from the issue of whether uncompensated hospital care leads to unfair competition between hospitals, the fate of financially distressed hospitals has implications for access to care—particularly in the care of small rural hospitals which do *not* have nearby competitors. In North Carolina, there is not a strong relationship between level of uncompensated care and financial performance: hospitals with deficits are not necessarily the ones with the highest level of uncompensated care. Conversely, hospitals with high levels of uncompensated care do not necessarily run deficits. Thus, even if a pool or "fair share" approach were adopted to level differences in indigent care loads across hospitals, some facilities might continue to have financial problems.

Currently, North Carolina provides technical assistance to financially troubled hospitals. But if the state wished to lay a more active role in preventing hospital closures, it could elect to provide direct public grants to hospitals. For example, some states, such as Colorado, provide lump sum payments to hospitals which exceed a certain minimum level of charity care. Louisiana funds an entire system of 9 charity hospitals which provide care to eligible indigents. Iowa, like North Carolina, appropriates funds to its major state teaching hospital to cover teaching and indigent care costs. However, in Iowa, since counties are legally responsible for the cost of indigent care, counties are given a quota of indigent residents who may be treated at this hospital at no cost. Once the quota is exceeded, counties must reimburse the costs of care for additional patients. Iowa also has established a statewide transportation system to bring patients to the state hospital when needed.

Aside from N.C. Memorial, the only other hospital in North Carolina which now receives an appropriation for indigent care is Pitt County Memorial Hospital (with the express proviso that such funds be used only to cover indigent costs of non-Pitt County residents). There also are a number of county governments which provide direct reimbursement to county-owned facilities to offset some of their indigent care costs.

LEVEL FINANCIAL BURDEN ACROSS PHYSICIANS

National data show that 2.4 percent of gross billings for the average physician are absorbed by charity care to needy patients, plus an additional 8.4 percent for bad debts. Assuming that similar figures apply in North Carolina, physicians already provide nearly $200 million a year in uncompensated services. As with hospitals, the burden of free care is not evenly distributed—in part because the number of people in need varies dramatically across counties. Some counties have as few as 40 uninsured poor people per practicing primary care provider, while other have 1300. The insured poor—principally those on Medicaid—may also have difficulties in access to physicians; on average, only 51 percent of North Carolina's physicians accept Medicaid clients, but this willingness varies across counties.

Although many physicians are willing to provide pro bono services, they may be reluctant to publicly identify themselves as the local free care doctor for fear of being inundated by patients who cannot pay. They might be more willing to offer their services if they knew that others in their area were doing likewise. In addition, even if the physician is willing to donate time, patients have other medical needs, such as drugs, equipment, or hospital care, that the physician cannot provide.

Physician Fair Share Program: In Kentucky, roughly half of physicians statewide have agreed voluntarily to provide a limited amount of free care to financially needy individuals (1 visit per person). Patients in need of such care call a statewide toll- free number maintained by the state medical society and are referred to physicians in their local area who have volunteered under this program. Some of the costs of this program were defrayed by a private foundation, and eligibility is determined through the state's Department of Social Insurance. There are many other community-wide efforts by physicians to ensure access to needed medical services for those who cannot pay. In North Carolina, the state could encourage the medical society to create similar programs: in exchange for the agreement of physicians to donate their time, the sate might defray certain components of such a program (e.g., the administrative costs associated with establishing and operating a statewide telephone referral line; payment for drugs, as is now done for certain aged, blind and disabled patients; provision of transportation services to patients needing care, etc.).

Mandatory Assignment: Massachusetts has recently enacted legislation which requires that all physicians accept assignment on Medicare cases, meaning that they accept Medicare reimbursement as

payment in full and will not bill patients for the balance. Four other states (California, New Jersey, Rhode Island and Washington) are considering similar action. Massachusetts is also considering requiring all physicians to accept Medicaid patients as a condition of licensure. Recently, the Massachusetts department of health tied the issuance of a hospital's certificate of need for a new facility to a requirement that at least 85 percent of specialists using the new facility participate in Medicaid.

REMOVE BARRIERS TO PATIENT ACCESS

Emergency Care Standards: To avert "dumping" of patients who cannot pay by transferring them to other (usually public) hospitals, some states have clarified the circumstances under which providers are expected to render emergency care services (e.g., Texas). An example of where clarification might be necessary concerns women in labor. Hill-Burton regulations specifically include women in labor as emergency cases and require that facilities render services without regard to ability to pay. However, not all facilities have Hill-Burton obligations, and there are instances in other states where women in labor literally have gone from hospital to hospital in search of one which would admit them. There is no systematic data regarding the extent to which patients in North Carolina are denied hospital care in potential emergency situations.

Patient Transfer Standards: Some states (Texas and Florida) have enacted anti-dumping provisions that require hospitals to stabilize patients before transferring them. These provisions have been superseded by a new federal law which requires that all facilities which accept Medicare patients must render emergency care to all patients in need. They also are not permitted to transfer such cases except after they are stabilized and the receiving facility has been notified. Moreover, transfers for economic reasons alone are not permitted: the only grounds for transfer has to be a hospital's lack of needed services to assist the patient. In view of this new development, no additional action at the state level appears necessary.

COMMISSION RECOMMENDATIONS

RECOMMENDATIONS

SUBCOMMITTEE ON GOVERNMENT OPTIONS

SUMMARY
SUBCOMMITTEE ON GOVERNMENT OPTIONS
RECOMMENDATIONS

PRIORITY I

The Commission recommends the General Assembly adopt legislation that will increase the availability of prenatal and maternity for pregnant women and increase the availability of pediatric care for infants. Specifically, The Commission recommends the following legislative action:

A. Expand the Medicaid program to provide coverage for Pregnant Women and Infants (up to age 1) with family incomes equal to or below 185% of the Federal Poverty Guidelines.

B. Provide state funds to support the non-federal share of local administrative costs associated with this Medicaid program expansion.

C. Increase the Medicaid Program's Reimbursement to Physicians for prenatal and maternity care services.

D. Expand the Rural Obstetrical Program Pilot administered by the Department of Human Resources, Division of Health

PRIORITY II

The Commission recommends increasing the availability of health care services for children whose family incomes are below 100% percent of the federal poverty guidelines. Specifically the Commission recommends:

A. Expand the Medicaid Program to cover children born after September 30, 1983 until the child reaches the age of eight if the family income is equal to or below 100% percent of the federal poverty guidelines.

B. Provide state funds to support the non-federal share of local administrative costs associated with this Medicaid program expansion.

C. Designate Case Management a Medicaid covered service for children under the age of eight whose family incomes are below the federal poverty guidelines and who are considered to be at risk for special health problems.

D. Expand The Children Special Health Services Program to provide inpatient services for children under age 21 whose family incomes are equal to or below 100% of the federal poverty guidelines.

PRIORITY III

The Commission recommends that the General Assembly increase the Medically Needy Income Guidelines by 10% each year for the next five years until the Medically Needy Income limit reaches 75% of the federal poverty guidelines.

PRIORITY IV

The Commission recommends that the General Assembly expand Medicaid coverage for Elderly, Blind and Disabled citizens:

A. Designate all Supplemental Security Income (SSI) beneficiaries automatically eligible for Medicaid Coverage, and increase the income eligibility guidelines for Elderly, Blind and Disabled individuals to 75% percent of the federal poverty guidelines.

B. Provide state funds to support non-federal share of local program administration costs which are associated with this Medicaid program expansion.

C. Adopt Supplemental Security Income Resource Limits as resource limits for Medicaid beneficiaries.

PRIORITY IA
EXPAND MEDICAID COVERAGE FOR PREGNANT WOMEN AND FOR INFANTS

Recommendation: The Commission recommends the General Assembly adopt the maximum allowable Medicaid coverage limits for pregnant women and for infants and raise the income guidelines for these citizens to 185% of the federal poverty level. These new eligibility limits should be implemented January 1, 1990.

Rationale: For the past ten years, North Carolina's infant mortality rate has been one of the highest in the nation ranging from a low of 11.6 (1986) to a high of 16.6 (1978) per one thousand births. The state's 1987 infant mortality rate is 12.5 per one thousand births. Only five states have a higher infant death rate than North Carolina.

Infant Mortality is strongly associated with access to prenatal care. National studies have shown that for every one dollar spent in prenatal care, there is a three dollar savings in long term health care costs from reduced neonatal intensive care and treatment for mentally retarded children. Similarly, expanding the Medicaid income guidelines for infants will help ensure that low birth weight babies obtain necessary treatment for healthy development.

A family of three with an income of 185% of the federal poverty level has an income of less than $18,000 gross income a year or $1,500 a month. Charges of $1,200 for a physicians maternity care package represents nearly one months gross income for such a family.

This recommendation will provide coverage for 9,700 additional women during the term of their pregnancy and for 10,100 infants until they reach the age of 1 year.

COSTS:

	ANNUAL	*FY 89-90*
Total:	$51,014,324	$25,507,161
Federal:	$34,414,262	$17,204,131
County:	$ 2,489,499	$ 1,244,750
STATE:	**$14,110,562**	**$ 7,055,281**

PRIORITY IB
STATE AID TO LOCAL DEPARTMENTS OF SOCIAL SERVICES FOR NEW ELIGIBILITY WORKERS

Recommendations: The Commission recommends that the state fund the non-federal share of local administration cost associated with the implementation of these recommendations. These funds should be used to hire additional county personnel, a portion of which should be placed at appropriate outpost locations such as health departments, public hospitals, and senior citizen centers. Funding for these positions should begin three months prior to the implementation of the program.

Rationale: Historically, the state has limited its funding for local administration of county departments of social services. Local departments are struggling to meet the demands of implementing Congress' Catastrophic Health Care Legislation and their current caseloads. If the recommendations of this Commission are adopted, county departments will need additional workers to process the additional applications. From the body of potential applicants for all these recommendations, it is estimated that an additional 193,900 persons will be eligible for Medicaid coverage.

COSTS:

	*FY 89-90**	*FY 90-91*
Total	$1,558,500	$2,118,000
Federal	794,250	1,059,000
Non-Federal Share	**794,250**	**1,059,000**

*Funding effective 10/1/89 if program is implemented 1/1/90.

PRIORITY IC
INCREASE PHYSICIAN REIMBURSEMENT FOR MATERNITY CARE

Recommendation: The Commission recommends that the General Assembly appropriate additional funds to the Division of Medical Assistance to increase physician reimbursement for maternity care services. The increase should take effect October, 1989.

Rationale: The average fee for prenatal care and delivery are roughly $1,200 to $1,500. Medicaid fees for obstetric services are estimated to be approximately 54% of average physician charges. These low fees and the rising cost of malpractice insurance for physicians who provide obstetric care make physicians reluctant to take Medicaid patients. Thus, patients have restricted access to health care. The Commission recommends physician fees for obstetrical care be increased from $625 to $950 for prenatal care and delivery services.

COST:

	FY 89-90	*FY 90-91*
Total:	$3,450,000	$4,820,000
Federal:	2,343,930	3,269,888
County:	155,250	216,900
STATE:	**950,820**	**1,333,212**

PRIORITY ID
EXPAND RURAL OBSTETRICAL INCENTIVE PROGRAM

Recommendation: The Commission recommends that the Rural Obstetrical Program be expanded in the next biennium to encourage participation among more physicians. The Department of Human Resources, Division of Health Services should conduct an evaluation of the program for review by the 1991 General Assembly.

Rationale: The 1988 General Assembly appropriated $240,000 for the implementation of a Rural Obstetrical Incentive Program (Sec. 39.3 of Chapter 110 of the 1987 Session Laws). With this appropriation, the Division of Health Services established a pilot program that compensates family physicians and obstetricians who agree to provide prenatal and obstetrical services. Only physicians in counties which are designated as "underserved" by the Commission for Health Services may qualify. This compensation is intended to assist the physician with the difference between his insurance premiums without obstetrical service and his premium with obstetrical service. The compensation is capped at $6,500 per physician.

A county is considered underserved with respect to obstetrical care if the county meets one or more of the following criteria, listed in order of priority:

(1) there are no public or private prenatal services available within the county;

(2) there is no public prenatal clinic available within a health department, hospital or primary care center that serves low income pregnant women within the county;

(3) there is a public prenatal clinic, but no physician to staff the clinic or to provide physician back-up for physician extenders;

(4) the county has inadequate obstetrical coverage, demonstrated by such factors as a waiting list of 28 calendar days or more for an appointment at the public prenatal clinic or 50% or more of resident live-births occurring outside of the county;

(5) implementation of these rules would preserve county obstetrical services threatened with discontinuation.

It is estimated that an additional 100 physicians could be persuaded to provide obstetrical services in FY 89-90 at a cost of $650,000. In FY 90-91, another 50 physicians could be included in the program at a total cost of $1,000,000. Compensation per physician would be capped at $6,500 annually.

COST:

FY 89-90:	$ 650,000
FY 90-91:	$1,000,000

PRIORITY IIA
EXPAND MEDICAID COVERAGE
COVER CHILDREN UNDER AGE 8

Recommendation: The Commission recommends that the General Assembly elect to provide Medicaid coverage to children born after September 30, 1983 until the child reaches the age of eight (8) if the family's income is equal to or below the 100% of the federal poverty level. This coverage should be implemented beginning October 1, 1989.

Rationale: The Omnibus Reconciliation Act of 1986 allowed states the option of covering children with family incomes below the poverty level. Under a federal phase in schedule, states could cover children under age 2 as of October, 1987 and children under age 3 as of October, 1989. Children ages 4 and 5 were to be phased in annually by October 1991. The 1987 General Assembly elected to provide coverage for children under age 5 in keeping with this schedule. The 1987 Omnibus Reconciliation Bill eliminated this restrictive time frame and allowed states to cover all children under age 5 as of July, 1988, rather than wait until October 1990 to do so.

The 1987 Omnibus Reconciliation Bill also permitted states to continue coverage for all low income children born after September 30, 1983 until they reach the age of 8, if the family income is below the poverty level. In other words, under current law, children up to age 7 could be covered by the Medicaid Program beginning October, 1989. Since only children born after 1983 may qualify, coverage for children age seven to eight will be phased in after October, 1990.

Providing health services to children provides a long-term cost savings. Several studies have shown medical costs savings for children who receive comprehensive preventive care. For example, a Texas study estimated a savings of $8 for every $1 spent on preventive services for children. In Alabama, savings of between 4% and $10 were calculated in prevented illness for each $1 spent. Similarly, a study in Pennsylvania fund that children participating in a comprehensive preventive health program had 30% fewer long-term health problems, with lower health care costs.

The 1988 federal poverty level is $9,690 per year for a family of three.

COST:

CHILD'S AGE	*NUMBER* ELIGIBLE	*FY 89-90 COSTS* (EFF. 10/89)	*FY 90-91* COSTS
4 to 5	9,000	$1,701,000[1]	$ 621,000[1]
5 to 6	8,500	$1,453,000	$1,938,000
6 to 7	8,500	$1,453,000	$1,938,000
7 to 8	8,500	-0-[2]	$1,453,000
Total:	34,500	$4,607,000	$5,950,000
Federal:	N/A	$3,112,924	$4,013,638
County:	N/A	$ 224,111	$ 290,454
STATE:	N/A	**$1,269,965**	**$1,645,908**

[1] Cost shown here are costs above those calculated for the 1989-91 Medicaid continuation budget under the phase in schedule permitted by the 1986 Omnibus Reconcilliation Bill.

[2] Not eligible for coverage until 10/1/90.

PRIORITY IIB
STATE AID TO LOCAL DEPARTMENTS OF SOCIAL SERVICES FOR NEW ELIGIBILITY WORKERS

Recommendations: The Commission recommends that the state fund the non-federal share of local administration cost associated with the implementation of this recommendation. These funds should be used to hire additional county personnel, a portion of which should be placed at appropriate outpost locations such as health departments, public hospitals, and senior citizen centers. Funding for these positions should begin three months prior to the implementation of the program.

Rationale: Historically, the state has limited its funding for local administration of county departments of social services. Local departments are struggling to meet the demands of implementing Congress' Catastrophic Health Care Legislation and their current caseloads. If the recommendations of this Commission are adopted, county departments will need additional workers to process the additional applications. From the body of potential applicants for all these recommendations, it is estimated that an additional 193,900 persons will be eligible for Medicaid coverage.

COSTS:

	*FY 89-90**	*FY 90-91*
Total	$2,368,244	$2,368,244
Federal	1,184,122	1,184,122
Non-Federal Share	1,184,122	1,184,122

*Funding effective 7/1/89 for program expansion effective 10/1/89.

PRIORITY IIC
EXPAND MEDICAID COVERAGE
CASE MANAGEMENT SERVICES FOR CHILDREN WITH SPECIAL HEALTH RISKS

Recommendation: The Commission recommends the General Assembly designate case management as a Medicaid covered service for children under the age of 8 whose family incomes are under 100% of federal poverty level and who are considered to be at risk for special health problems. This recommendation should be implemented beginning January 1, 1990.

Rationale: The delivery of health care to low income children would be enhanced by paying for case management services for children who are at risk for special health problems. Case management services will ensure that these children have access to health care by providing transportation and other necessary social services.

Currently, the Medicaid program pays for case management services for pregnant women who help to ensure that pregnant women apply for Medicaid, receive needed food supplements under the WIC program, and get to their doctors appointments. The Medicaid program also pays for case management services for individuals who are chronically mentally ill.

COSTS:

Estimated Age Group	Total Number	State Cost	County Share	Share
0 -	1,392	$ 626,400	$ 172,573	$ 30,454
1 - 3	2,054	924,300	254,645	44,937
3 - 5	2,612	1,175,400	323,823	57,145
6 - 8	2,484	1,117,800	307,954	54,344
TOTAL ANNUAL	8,542	$3,843,900	$1,058,995	$186,880
FY 89-90 (Eff 1/90)		$1,921,950	$ 529,498	$ 93,440

PRIORITY IID
EXPAND INCOME ELIGIBILITY FOR CHILDREN WITH SPECIAL HEALTH SERVICES PROGRAM

Recommendation: The Commission recommends that the Divisioin of Health Services use the savings from the expanded Medicaid coverage for children to expand the income guidelines for children with special health needs for inpatient services.

Rationale: The Children with Special Health Services program provides health and rehabilitative services to children under age 21 with chronic health conditions. Up until 1987, the income guidelines for inpatient and outpatient care was approximately 67% of the federal poverty guidelines. In 1987, the General Assembly increased the income guidelines up to 100% of the federal poverty guidelines for all children for outpatient care and for children under age 5 for inpatient care. However, the income guidelines for children between ages 5 and 21 for inpatient services remained at 67% of the federal poverty guidelines.

The Division of Health Services could use its savings from the expanded Medicaid coverage of children under age 8 to increase the income guidelines for children under age 21 for inpatient services.

Costs: There will be no costs associated with this recommendation.

PRIORITY III
INCREASE MEDICALLY NEEDY INCOME LIMITS

Recommendation: The Commission recommends that the General Assembly increase the Medically Needy/AFDC income limit by 10% each year for the next five years, until the Medically Needy Income Limit reaches 75% of poverty. The first 10% increase would become effective January 1, 1990.

Rationale: This recommendation would expand coverage to everyone who is categorically eligible for Medicaid, including aged, blind and disabled people, families with dependent children, pregnant women, and children under age 21. People with "excess" income could become eligible if they incurred medical bills equal to the difference between their countable income and the Medically Needy Income Level.

The eligibility limit for North Carolina's medically needy program for an elderly and disabled individual is 50% of the federal poverty level. Federal Law ties the income limit for the Medically Needy Program to 133% of the states AFDC payment level. To increase the Medically Needy Income limit the state must increase the AFDC payment level. The General Assembly has not increased the Medically Needy Income Limit since 1987.

North Carolina has the 8th lowest AFDC benefit nationally. A single parent with two children and with no income is eligible for an AFDC cash benefit of $266 per month or $3,192 annually. This AFDC benefit is equal to 33% of the 1988 federal poverty level for a family of three. The purchasing power of AFDC and Food Stamps have declined 32% since 1972.

CURRENT MEDICALLY NEEDY/AFDC LIMITS

Family Size	1988 FPL/mo.	AFDC PYMT/mo. (% FPL)	M'aid Limits/Mo. (% FPL)
1	$ 481	$177 (37%)	$241 (50%)
2	$ 644	$231 (36%)	$308 (48%)
3	$ 807	$266 (33%)	$358 (44%)
4	$ 971	$291 (30%)	$392 (40%)
5	$1,134	$317 (28%)	$425 (37%)

The Divisions of Social Services and Medical Assistance are developing cost estimates for this proposal.

PRIORITY IVA
EXPAND MEDICAID COVERAGE
INCREASE INCOME GUIDELINES FOR THE ELDERLY, BLIND AND DISABLED

Recommendation: The Commission recommends that the General Assembly make all Supplemental Security Income (SSI) beneficiaries automatically eligible for Medicaid and that the income guidelines for elderly, blind and disabled individuals be increased to 75% of the federal poverty guidelines. These recommendations should be implemented effective April 1, 1990.

Rationale: Unlike 36 other states, North Carolina does not automatically provide Medicaid to individuals who receive Supplemental Security Income (SSI) payments. As a result, there are currently 66,500 SSI recipients who do not receive Medicaid. North Carolina could assist these SSI beneficiaries, and could assist other elderly and disabled citizens whose income is equivalent to the SSI benefit level by eliminating the state's "209 (b)" status and raising the states income guidelines to 75% of the federal poverty level.

North Carolina's current income guidelines for elderly, blind and disabled individuals are roughly 50% of the federal poverty level (about $2,900 for a single person, $3,700 for a family of two). If North Carolina elected to cover elderly, blind and disabled persons with incomes below 75% of the federal poverty level, an additional 121,000 individuals would become eligible for coverage.

COSTS:

	FY 89-90 (Eff. 4/90)	FY 90-91	FY 91-92
Total:	30,497,691	108,589,592	92,511,942
Federal:	20,610,339	73,253,261	62,407,468
County:	1,482,188	5,300,450	4,515,671
STATE:	8,405,164	30,035,881	25,588,803

PRIORITY IVB
STATE AID TO LOCAL DEPARTMENTS OF SOCIAL SERVICES FOR NEW ELIGIBILITY WORKERS

Recommendations: The Commission recommends that the state fund the non-federal share of local administration costs associated with the implementation of this recommendation. These funds should be used to hire additional county personnel, a portion of which should be placed at appropriate outpost locations such as health departments, public hospitals, and senior citizen centers. Funding for these positions should begin three months prior to the implementation of the program.

Rationale: Historically, the state has limited its funding for local administration of county departments of social services. Local departments are struggling to meet the demands of implementing Congress' Catastrophic Health Care Legislation and their current caseloads. If the recommendations of this Commission are adopted, county departments will need additional workers to process the additional applications. From the body of potential applicants for all these recommendations, it is estimated that an additional 193,900 persons will be eligible for Medicaid coverage.

COSTS:

	FY 89-90[1]	*Annual*
Total	$3,500,000	$7,000,000
Federal	$1,750,000	$3,500,000
NON-FEDERAL SHARE	**$1,750,000**	**$3,500,000**

[1] Funding effective 1/1/89 for program implementation effective 4/1/89

PRIORITY IVC
EXPAND MEDICAID COVERAGE
ADOPT NEW RESOURCE SPEND LIMITATIONS

Recommendation: The Commission recommends that the General Assembly adopt the Supplemental Security Income (SSI) resources limits as the minimum resource limitations for the Medicaid Program. The Commission also recommends that the Division study new federal provisions under The Catastrophic methodologies to current spend down rules.

Rationale: To qualify for Medicaid, a person must pass income and resources (assets) tests. The current resource limitations for Medicaid applicants could be increased to a level compatible with the Supplemental Security Income Program. The resource limitations are as follows:

Family *Size*	Current Medicaid *Limits*	Proposed (SSI) *Limits*
1	$1,500	$2,000
2	$2,250	$3,000

Increasing these limits will simplify the current application procedure and will allow beneficiaries to keep a larger portion of their limited resources for other personal emergencies.

Individuals whose income exceeds allowable income limits may "spend down" their income and become eligible for Medicaid. That is, they may pay a "deductible" or a sum equal to the difference between their income and the income limit. Until recently, the federal government has not permitted states to adopt a resource spend down policy. The federal Catastrophic Health Care Act of 1987 contains a provision that permits states to apply "less restrictive methodologies" to the resource test portion of the eligibility determination process. In the hope of simplifying the determination process, and treating applicants more equitably, the Commission recommends that the Division of Medical Assistance study this federal provision and develop alternatives to current resource test policies where permitted under federal law.

COSTS:

	Annual
Total:	$14,300,000
Federal:	9,665,118
County:	695,232
STATE:	**3,939,650**

RECOMMENDATIONS

SUBCOMMITTEE ON PRIVATE OPTIONS

COMMUNITY HEALTH ACCESS PROGRAM

Rationale:

There is a large group of low-payed uninsured workers, both full and part-time, many of whom work for very small firms, who will remain largely untouched by strategies designed to expand employer-sponsored insurance coverage. These small employers are unable or unwilling to voluntarily offer insurance coverage to their workers. The Community Health Access Program is designed to improve and expand the capacity of community health delivery systems to better serve these uninsured working poor.

Recommendation:

The Subcommittee recomends that the Indigent Care Study Commission recommend to the General Assembly the funding of a competitive demonstration program in which a limited number of grants are offered to communities/counties to develop and operate a health delivery system to better serve low-payed, uninsured workers. New systems are to be developed or existing delivery system expanded to cost-effectively deliver primary and preventive care services and to arrange for necessary referral and support services for the uninsured poor.

Cost:

$400,000 in state appropriations to fund, over a two year period, 5 developmental grants which will design health delivery systems and $1.44 million in state appropriations to fund the systems for a two-year period. Program administration cost would be $170,000. Total 2-year cost of the project would be $2,010,000.

(See Appendix C, pages *C1* through *C4* for a more detailed description of this program)

LEGISLATION TO REDUCE BARRIERS TO EMPLOYER-SPONSORED COVERAGE

Rationale:

There are 386,000 uninsured workers in N.C., and half of them work for employers who offer a group health insurance program. There are several barriers to coverage for employees who are employed by these businesses, many of which can be addressed through legislative changes.

Recommendations:

The subcommittee recommends that the Commission endorse the introduction of legislation related to group health coverage:

1. Which requires all insurance contracts, including those written on an out-of-state trust arrangement, to comply with the following recommended changes. Since many small employer groups are written on an out-of-state trust arrangement, it is essential to make clear in the law that the following recommended changes will apply to these arrangements also.

(See Attachment 1, Appendix C, pg. 5 for draft legislation)

2. Which prohibits insurers from medically underwriting groups of 20 or more individuals. This legislation would help reduce the incidence of excluding certain individuals from coverage because of poor health.

(See Attachment 2, Appendix C, pg. 6 for draft legislation)

3. Which limits pre-existing conditions exclusions to six months and prohibits the re-implementation of that portion of the waiting period met under a previous plan by a person who has changed insurers. Because of the serious problem of infant mortality in N.C. and of the need for a broad base approach to reducing infant mortality, pregnancy is to be excluded from the definition of pre-existing condition.

(See Attachment 3, Appendix C, pg. 7 for draft legislation)

4. Which limits the waiting period for new employees before they become eligible for coverage under the group plan to a period not to exceed 90 days from their first day of employment and which also requires that any pre-existing condition exclusion be computed from the first day of employment rather than the effective date of coverage under the health plan. The legislation would also define employee as any person working seventeen and one-half hours in any one week.

(See Attachment 4, Appendix C, pg. 8 for draft legislation)

5. Which requires insurers replacing employer group health insurance plans to continue to insure all persons validly covered (including benefit extension) under the prior group plan if such person is a member of the class or classes of individuals eligible for coverage under the succeeding insurer's plan but for some reason, such as not being actively at work on the day the succeeding insurer's plan takes effect, is not immediately eligible for coverage.

(See Attachment 5, Appendix C, pg. 9 for draft legislation)

The above legislation would take effect not before three months and no later than fifteen months after ratification of the bill.

HEALTH INSURANCE POOLS

Rationale:

Health insurance pools have been one mechanism used by states to address the insurance needs of their uninsured residents. High- risk pools for the medically uninsurable and pools for uninsured workers have been implemented in several states. By pooling the uninsured on a state-wide basis, insurance coverage which had previously been unavailable or unaffordable can be offered.

The Health Insurance Trust Commission is studying a proposal to establish a risk pool for medically uninsurables employed by firms with fewer than 25 employees. The subcommittee recognizes the benefits of pools for the uninsured and recommends the concept for further study.

Recommendation:

The subcommittee recommends that the Commission endorse the efforts of the Health Insurance Trust Commission in regard to its study of a high-risk pool for employees of small businesses and that the Trust Commission consider expanding its pool to include all medically uninsurables and not limit it to employees of small businesses (25 or less employees). It also recommends that the financing of the pool be built upon the broadest base possible.

(See Appendix C, pgs. *10* through *22* for data describing the populations targeted by Health Insurance Pools)

APPENDIX A

FULL COMMISSION

-----INDIGENT CARE STUDY COMMISSION

Sec. 71. (a) The Indigent Health Care Study Commission, established by Section 6.1 of Chapter 792 of the 1985 Session Laws, is continued as prescribed by this act.

(b) Duties of the Commission. The Commission shall study the issues of access to and financing of health care services for North Carolinians who are unable to pay for their medical care. Among the issues to be examined by the Commission are the following:

(1) The identification of the medically indigent, including an examination of the uninsured and the underinsured;

(2) The barriers, if any, that the medically indigent face in receiving timely and cost-effective health care under the current health care system;

(3) The effects that the trend toward prospective reimbursement in a more competitive health care environment will have on the ability of health care providers to deliver health care to uninsured or underinsured citizens;

(4) The identification of the entities that currently pay for the health care provided to the medically indigent, and an examination of the distribution of the financial burden of providing health care to the medically indigent among hospitals, physicians, HMOs, counties, third-party insurers, employers, the State of North Carolina, the federal government and the medically indigent;

(5) The current extent of State and local responsibility for providing health care to the medically indigent; and

(6) The different options for financing and delivering health care to the medically indigent.

(c) The Commission shall consist of 16 members, as follows:

(1) The Secretary of the Department of Human Resources shall serve ex officio as a voting member;

(2) The Insurance Commissioner shall serve ex officio as a voting member;

(3) Three members of the House of Representatives appointed by the Speaker of the House;

(4) Three members of the Senate appointed by the President of the Senate;

(5) One hospital administrator appointed by the Governor;

(6) One representative of county government and one county public health director, both appointed by the Speaker of the House;

(7) One medical physician who provides a substantial amount of health care to indigents, appointed by the Governor;

(8) One representative of a health insurance company providing a substantial number of North Carolina citizens with health insurance and one licensed nurse, both appointed by the President of the Senate;

(9) One advocate for low income people who is familiar with indigent health care issues appointed by the Speaker of the House; and

(10) One representative from the business community appointed by the President of the Senate.

Any vacancy shall be filled by the appointing authority who appointed the person causing the vacancy. All initial appointments shall be made within one calendar month from the effective date of this Part.

(d) The Commission shall have its initial meeting no later than September 15, 1987, at the call of the President of the Senate and Speaker of the House. The President of the Senate and the Speaker of the House of Representatives shall appoint a cochairman each from the membership of the Commission. The Commission shall meet upon the call of the cochairmen.

(e) The Commission members shall receive no salary serving on the Commission but shall receive necessary subsistence and travel expenses in accordance with the provisions of G.S. 120-3.1, G.S. 138-5 and G.S. 138-6, as applicable.

(f) The Commission may hold public meetings across the State to solicit public input with respect to the issues of access to and financing of health care services to the medically indigent.

(g) The Commission shall have the authority to obtain information and data from all State officers, agents, agencies and departments, while in discharge of its duties, pursuant to the provisions of G.S. 120-19, as if it were a committee of the General Assembly. The Commission shall also have the authority to call witnesses, compel testimony relevant to any matter properly before the Commission, and subpoena records and documents, provided that any patient record shall have patient identifying information removed. The provisions of G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Commission as if it were a joint committee of the General Assembly. In addition to the other signatures required for the issuance of a subpoena under this section, the subpoena shall also be signed by the cochairmen of the Commission. Any cost of providing information to the Commission not covered by G.S. 120-19.3 may be reimbursed by the Commission from funds appropriated for the Commission's study.

(h) The Commission shall report to the General Assembly and the Governor the results of its study and recommendations. The final report shall be submitted during the 1989 Session of the General Assembly.

(i) At the request of the Commission, the Legislative Services Commission may supply members of the staff of the Legislative Services Office and clerical assistance to the Commission as it deems appropriate.

(j) The Commission may, with the approval of the Legislative Services Commission, meet in the State Legislative Building or the Legislative Office Building.

(k) Of the funds appropriated from the General Fund to the Legislative Services Commission by Section 2 of this act, the sum of twenty-five thousand dollars ($25,000) for the 1987-88 fiscal year shall be used to fund the study authorized by this section.

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Ms. Pam Silberman, Chair

Representative Howard Barnhill

Mr. Russell Childers

Secretary David Flaherty

Representative Walter Jones

Senator Tony Rand

Mr. Russell Tranbarger

Dr. Eugene Wade

Senator Russell Walker

Mr. Paul Wiles

INDIGENT HEALTH CARE STUDY COMMISSION

SUBCOMMITTEE

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Representative Howard Barnhill

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Representative Roy Cooper

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REPORTS TO THE COMMISSION

"Health Care for the Medically Indigent of North Carolina: 1987 Progress and Future Possibilities"

"Health Care for the Medically Indigent of North Carolina: Background Briefing for New Members"

1987 GENERAL ASSEMBLY ACTION ON INDIGENT HEALTH CARE

Acting on the recommendations of the 1986 Indigent Care Study Commission, the 1987 General Assembly enacted several enhancements to North Carolina's Medicaid Program. The enhancements include:

- Coverage for pregnant women and for children up to age 5 whose family income is below 100% of the federal poverty level ($9,690 for a family of three). Benefits for children will be made available in accordance with the schedule established by the federal government.
- Coverage for two-parent families where the principle wage earner is recently unemployed. The families income may not exceed approximately 67% of the federal poverty level (about $6,384 annually for a family of three).
- Coverage for 19-21 year old children of eligible single parent families.
- Coverage for employed single parent families who are eligible for Aid to Families With Dependent Children with income up to 68% of the federal poverty level. In the past, families could only earn about 32% of the federal poverty level before losing Medicaid benefits.
- An increase of 2.5% to the eligibility thresholds for medical and cash benefits provided under the Medicaid and Aid to Families with Dependent Children Programs.
- Appropriation of $1.5 million dollars in each year of the biennium to provide County Departments of Social Services with additional staff to process new applications.

In addition to enhancements to the Medicaid program, the General Assembly adopted three additional legislative recommendations of the Indigent Care Study Commission.

- The Division of Medical Assistance has been granted authority to develop a new plan for the reimbursement of hospitals who provided health care to uninsured North Carolinians. The plan will be developed over the next year and will require the approval of the federal regulatory agencies.
- The North Carolina Health Care Trust Commission was created and located in the Department of Insurance. This Commission is charged with the responsibility of developing a health benefit program that can be made available to small employers with 25 or fewer employees. The Commission's goal will be to develop a limited benefit plan market it through demonstration projects.

APPENDIX B

SUBCOMMITTEE ON GOVERNMENT OPTIONS

INDIGENT HEALTH CARE STUDY COMMISSION
SUBCOMMITTEE ON GOVERNMENT OPTIONS

GOVERNMENT OPTIONS

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Rep. Howard Barnhill

Mr. Russell Childers

Secretary David Flaherty

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INFORMATION PRESENTED TO THE SUBCOMMITTEE ON GOVERNMENT OPTIONS

BABYLOVE Outreach Program and Presumptive Eligiblity Procedures: Department of Human Resources Division of Medical Assistance.

BABYLOVE Maternity Care Coordinators Program: Department of Human Resources Division of Medical Assistance and Division of Health Services.

Overview of Maternal and Child Health Services in Public Health Departments: Department of Human Resources Division of Health Services.

Women Infants and Children Program (WIC) Report: Department of Human Resources, Divison of Health Services.

Study of Physician Participation in the Medicaid Program: Department of Human Resources, Division of Medical Assistance with Division Of Health Services Center for Health Statistics.

Overview of Adult Health Programs Administered by Local Public Health Programs: Department of Human Resources Division of Health Services, Adult Health Section.

Prescription Drug Program: Department of Human Resources Division of Health Services.

Implementation of The Federal Catastrophic Health Care Act of 1987: Department of Human Resources Division of Medical Assistance.

APPENDIX C

SUBCOMMITTEE ON PRIVATE OPTIONS

RECOMMENDATION 1

COMMUNITY HEALTH ACCESS DEMONSTRATION PROGRAM

Almost 200,000 of North Carolina's uninsured full-time and part-time workers are under poverty. Over 400,000 are under 200% of poverty. This large group of low-paid uninsured, many (44%) working in small firms with fewer than 9 employees, will remain largely untouched by strategies designed to expand employer sponsored insurance coverage. Our employer interviews indicated that these smaller less stable employers cannot or will not voluntarily offer insurance coverage. Even in the few cases where these employers are moved to offer insurance coverage, the prospects of low-paid workers purchasing family coverage is equally remote. The money is just not there to buy into a rapidly escalating health care system. Barring a sweeping expansion of Medicaid or implementation of universal coverage, this segment of the uninsured will continue to be left out.

Though there is no ideal approach, one approach can help bridge the gap until more permanent solutions are achieved. If communities were provided assistance in improving and expanding the capacity of their existing delivery systems to better serve the uninsured poor, there would be an immediate improvement in access. We propose that the State establish a competitive 4 year demonstration program with a limited number of grants available to communities to develop and operate a coordinated delivery system to serve the uninsured working poor. No matter what long-term solutions to the uninsured problem are instituted, improving how care is managed and delivered will have to be part of any solution.

Care for the uninsured poor is now heavily weighted toward expensive inpatient and hospital-based outpatient services. Too often the uninsured poor do not get the primary and preventive care they need when they need it. A recent study indicates that 1/3 of the hospital care provided to the uninsured could have been avoided by earlier detection and treatment. The primary goal of this proposed grant program is to change the location, timing, and focus of care. We propose that grant funds be used to expand existing delivery systems or to develop new delivery systems to cost-effectively deliver primary and preventive care services, and to arrange for necessary referral, hospital, and support services for the uninsured poor.

This program is also intended to be a vehicle for raising community awareness and action. A successful applicant will have to demonstrate strong community support for the local project. Through the demonstration program the State would assist communities and their health care providers organize to provide directly or to arrange access to the following services for eligible uninsured:

- Primary and preventive services
- Ancillary services
- Referral to specialty and inpatient services
- Outreach and education

Those eligible for the services will be the uninsured with incomes below 200% of poverty. They will participate on the basis of income. A sliding fee scale will be used to determine what portion of the costs will be assumed by the individual. Eligible recipients will enroll in the community plan.

A certain amount of flexibility will be built into the program to respond to the diverse needs and circumstances of participating communities.

ELIGIBILITY

Grants will be awarded to not-for-profit or public hospitals in rural areas. In counties without an eligible hospital or where an eligible hospital does not apply, the following organizations may apply; primary care centers, county or community agencies, and provider associations.

Applicants must demonstrate the commitment and capability to expand the capacity of their existing delivery system to better serve the uninsured poor. This delivery system would include:

- A primary care physician network.
- A referral network of specialists, and other needed support services.
- Arrangements for 24 hours a day, 7 days a week coverage, including assistance in obtaining needed inpatient and specialty services
- Access to ancillary services.

Applicants should also demonstrate:

- Ability to develop and maintain the networks and to effectively manage the care.
- Ability to administer the project.
- Community support for the project, including local contributions.
- Outreach and educational efforts designed to bring eligible people into the system and to help them qualify, where appropriate, for comprehensive coverage.
- Willingness to work with local employers not offering insurance to encourage their participation on behalf of employees.

GRANTS

For successful applicants grant funds would be awarded in two categories:

Coordination and Administration

Up to $40,000 annually would be available to cover the costs of:

- Developing and maintaining the primary care networks and the linkages with other providers and support systems.
- Program administration, including utilization management activities.
- Conducting outreach and educational efforts, including assisting the eligible uninsured qualify for Medicaid and/or Medicare.
- Marketing the program to local employers not offering insurance to encourage their participation on behalf of eligible employees.

Primary Care and Preventive Package

For each eligible person enrolled in the Community Health Access Program the State will pay the grantee a fixed amount on a per member/per month basis to cover the anticipated costs of providing the following services contained in the Primary and Preventive Care Package:

- Preventive services for children and adults
- Prenatal care
- Maintenance services for those with chronic illness
- Acute Care
- Lab/x-ray

The proposed preliminary rate is set at $20 per person/per month. Any surplus funds generated from individual and employer contributions or from program efficiencies can be used to purchase additional services, including drugs and specialty care. Though the grantee is only at risk for services contained in the Primary and Preventive Care Package, the program assumes that grantees will assist the eligible obtain needed care which is not covered.

GRANT ADMINISTRATION

We propose that the Office of Health Resources Development in the Department of Human Resources be responsible for grant administration including;

- Preparing application guidelines and materials
- Publicity
- Reviewing grant proposals
- Monitoring performance
- Providing technical assistance
- Establishing claims payment system
- Evaluation

PRELIMINARY COST ESTIMATES

Coordination and Administration

Amount: Up to $40,000 annually (actual amount based on submitted budget)
Period: 2 years
Number of grants: 5
Total Amount of Funds Needed: $400,000

Primary Care and Preventive Package

Amount: $20 per month per person (1000 member ceiling)
Period: 2 years
Number of grants: 4 (minimum)
Total Amount of Funds Needed: $1,920,000

Program Administration

Amount: $85,000 (assumes 2 staff plus support costs)
Period: 2 years
Total Amount of Funds Needed: $170,000

RECOMMENDATION II

REDUCE BARRIERS TO EMPLOYER SPONSORED COVERAGE

ATTACHMENT 1

All of the changes recommended below must apply to coverages issued to a trust located outside of North Carolina, which included participating employer units in this State. Language such as the following must be included in every section amended or in the applicability section of the proposed legislation to make it clear that these changes apply to such contracts since such contracts insure many small employer units in this State and to make these changes without specifically affecting these contracts would greatly reduce the effectiveness of these changes:

(a) This section applies to group accident, group health or group accident and health policies or certificates that are delivered, issued for delivery, renewed or used in this State which provide hospital, surgical, or major medical expense insurance, or any combination of these coverages, on an expense incurred basis. It specifically includes a certificate issued under a policy that was issued to a trust located outside of this State, but which includes participating employers located in this State. Renewal of these policies or certificates is presumed to occur on the anniversary date that coverage was first effective on the employees of such employer.

Changes must also be made to Chapters 57 and 57B where applicable to effect such changes to hospital and medical service corporations (Blue Cross Blue Shield) and health maintenance organizations (HMOs).

RECOMMENDATION II

REDUCE BARRIERS TO EMPLOYER SPONSORED COVERAGE

ATTACHMENT 2

Amend 58-254.4 (b) by redesignating the second paragraph thereof as (b) (1) and adding the following:

(2) For groups of twenty or more persons no evidence of individual insurability may be required at the time the person first becomes eligible for insurance or within thirty-one (31) days thereafter except for any insurance supplemental to the basic coverage for which evidence of individual insurability may be required. With respect to trusted groups the phrase "groups of twenty" must be applied on a participating unit basis for the purpose of requiring individual evidence of insurability.

RECOMMENDATION II

REDUCE BARRIERS TO EMPLOYER SPONSORED COVERAGE

ATTACHMENT 3

Add a new subsection to GS 58-254.4 designated as:

(3) Policies may contain a provision limiting coverage for pre-existing conditions. The pre-existing conditions must be covered no later than six (6) months after the effective date of coverage. Pre-existing conditions are defined as "those conditions for which medical advice or treatment was received or recommended or which could be medically documented within the six (6) month period immediately preceding the effective date of a person's coverage." Once coverage is in force, benefits for pregnancy and prenatal care must be provided and may not be excluded from coverage on the basis that the onset of the pregnancy occurred within the six (6) month period immediately preceding the effective date of coverage or employment, whichever period is longer. Pre-existing conditions exclusions may not be implemented in any successor plan as to any covered persons who have already met all or part of such waiting period requirements under any prior group plan. Credit must be given for that portion of the waiting period which was met under the prior plan.

RECOMMENDATION II

REDUCE BARRIERS TO EMPLOYER SPONSORED COVERAGE

ATTACHMENT 4

Amend 58-254.4 (c) by adding the following after the first sentence therein:

Employees shall be added to the group coverage no later than ninety (90) days after their first day of employment. Any pre-existing condition waiting periods shall be computed from the first day of employment, and not coverage under the group plan. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. Employee is defined as "any person working seventeen and a half hours in any one work week".

RECOMMENDATION II

REDUCE BARRIERS TO EMPLOYER SPONSORED COVERAGE

ATTACHMENT 5

Continuance or Coverage in Situations Involving Replacement of One Insurer's Group Health Plan by Another.

(a) Liability of the Succeeding Insurer.

(1) Each person who is eligible for coverage in accordance with the succeeding insurer's plan of benefits (in respect of classes eligible and activity at work and non- confinement rules) shall be covered by that insurer's plan of benefits.

(2) Each person not covered under the succeeding insurer's plan of benefits in accordance with paragraph (1), above must nevertheless be covered by the succeeding insurer if such person was validly covered (including benefit extension) under the prior plan on the date of discontinuance and if such person is a member of the class or classes of individuals eligible for coverage under the succeeding insurer's plan.

Table 1

ESTIMATED DISTRIBUTION OF WORKING UNINSURED
NORTH CAROLINA, 1986
(All Figures in Thousands)

	TOTAL NUMBER	TOTAL UNINSURED	MEDICALLY UNINSURABLE	PART-TIME/SEASONAL Workers	PART-TIME/SEASONAL Dependents	IN WAITING PERIOD Workers	IN WAITING PERIOD Dependents	FULL-TIME WORKERS Workers	FULL-TIME WORKERS Dependents
FIRM SIZE	3,024.0	388.7	38.1	123.2	34.5	43.5	72.2	265.5	202.2
Under 5	433.9	109.7	11.4	27.6	7.7	6.9	11.4	82.1	62.5
5 to 9	170.3	43.9	4.6	9.1	2.6	3.3	5.5	34.8	26.5
10 to 24	267.0	49.6	5.2	10.1	2.8	6.1	10.1	39.5	30.0
25 to 99	549.3	66.9	6.5	24.0	6.7	7.2	11.9	42.9	32.7
100 to 499	648.1	61.6	5.6	23.2	6.5	8.1	13.5	38.4	29.3
500 to 999	239.9	17.9	1.5	7.2	2.0	2.9	4.8	10.7	8.1
>1000	715.6	39.1	3.4	22.0	6.1	9.0	15.0	17.2	13.1
INDUSTRY	3,024.0	388.7	38.1	123.2	34.5	43.5	72.2	265.5	202.2
Construction	175.4	39.8	4.0	16.3	4.5	3.7	6.1	23.6	18.0
Retail Trade	393.1	87.4	8.8	38.3	10.7	4.7	7.7	49.1	37.4
Personal Services	55.2	17.1	1.7	9.7	2.7	0.5	0.9	7.4	5.6
Self-Employed	241.9	54.7	5.7	12.2	3.4	0.0	0.0	42.5	32.4
Manufacturing	870.9	72.3	6.6	29.2	8.2	15.9	26.3	43.1	32.8
POVERTY STATUS	6,331.3	896.4	100.0	123.2	34.5	43.5	72.2	265.5	202.2
Under 100%	977.4	381.9	69.4	44.	12.5	15.8	28.3	76.9	58.6
101-150%	592.7	117.6	12.2	21.1	5.9	7.5	13.1	38.6	29.4
151-200%	762.3	106.1	4.6	28.6	8.0	10.1	17.1	52.3	39.8
Over 200%	3,998.9	290.8	13.8	28.8	8.1	10.2	16.9	97.8	74.5

NCSIZE/Worksum

Table 2

ESTIMATED PREMIUM COST TO COVER WORKING UNINSURED
NORTH CAROLINA, 1986
(100 = Average Premium, Excluding Administrative Expenses)

	TOTAL NUMBER	TOTAL UNINSURED	MEDICALLY UNINSURABLE	PART-TIME/SEASONAL Workers	PART-TIME/SEASONAL Dependents	IN WAITING PERIOD Workers	IN WAITING PERIOD Dependents	FULL-TIME WORKERS Workers	FULL-TIME WORKERS Dependents
FIRM SIZE	100	109	239	111	80	100	82	100	82
Under 5	99	107	239	115	80	98	82	98	82
5 to 9	99	107	239	115	80	98	82	98	82
10 to 24	99	107	239	115	80	98	82	98	82
25 to 99	100	109	239	118	80	99	82	99	82
100 to 499	100	109	239	113	80	100	82	100	82
500 to 999	103	112	239	120	80	100	82	100	82
>1000	100	109	239	119	80	98	82	98	82
INDUSTRY	100	109	239	111	80	100	82	100	82
Construction	113	124	239	126	80	113	82	113	82
Retail Trade	104	113	239	115	80	104	82	104	82
Personal Services	100	109	239	111	80	100	82	100	82
Self-Employed	106	115	239	118	80	106	82	106	82
Manufacturing	101	110	239	112	80	101	82	101	82
POVERTY STATUS	119	129	239	111	80	100	82	100	82
Under 100%	145	145	239	136	89	122	91	122	91
101-150%	132	132	239	124	81	111	83	111	83
151-200%	126	126	239	118	77	106	79	106	79
Over 200%	109	109	239	102	67	92	68	92	68

NCSIZE/Premiums

NOTE: The figure shown for the medically uninsurable assumes a $75/month premium for full-time workers and is based on the current premium of $183 for the Blue Cross/Blue Shield SNAP plan for medically uninsurables. The figure shown is intended to fully cover costs for this group, without profit or loss to the carrier.

Table 3

ESTIMATED PREMIUM COST TO COVER WORKING UNINSURED
NORTH CAROLINA, 1986
(All Costs in Millions)

	ADMIN. COSTS	TOTAL UNINSURED	MEDICALLY UNINSURABLE	PART-TIME/SEASONAL Workers	PART-TIME/SEASONAL Dependents	IN WAITING PERIOD Workers	IN WAITING PERIOD Dependents	FULL-TIME WORKERS Workers	FULL-TIME WORKERS Dependents
FIRM SIZE	16.8%	$381.2	$82.0	$123.3	$15.1	$39.1	$32.7	$239.0	$150.0
Under 5	30.0%	$106.0	$24.6	$28.7	$3.4	$6.1	$5.2	$72.7	$46.4
5 to 9	20.0%	$42.5	$9.8	$9.5	$1.1	$2.9	$2.5	$30.6	$19.7
10 to 24	15.0%	$47.9	$11.1	$10.5	$1.2	$5.4	$4.6	$34.9	$22.3
25 to 99	11.0%	$65.8	$14.0	$25.5	$2.9	$6.4	$5.4	$38.1	$24.2
100 to 499	9.0%	$60.6	$12.0	$23.6	$2.8	$7.3	$6.1	$34.7	$21.7
500 to 999	8.0%	$18.1	$3.3	$7.8	$0.9	$2.6	$2.2	$9.6	$6.0
>1000	5.0%	$36.5	$7.2	$23.5	$2.7	$8.0	$6.8	$15.2	$9.7
INDUSTRY	0.0	$381.2	$82.0	$123.3	$15.1	$39.1	$32.7	$239.0	$150.0
Construction	0.0	$44.3	$8.6	$16.5	$2.0	$3.7	$2.8	$24.1	$13.3
Retail Trade	0.0	$88.9	$16.0	$39.8	$4.7	$4.3	$3.5	$45.8	$27.7
Personal Services		$16.7	$3.7	$9.7	$1.2	$0.5	$0.4	$6.6	$4.2
Self-Employed	0.0	$56.8	$12.3	$13.0	$1.5	$0.0	$0.0	$40.5	$24.0
Manufacturing	0.0	$71.6	$14.3	$29.6	$3.6	$14.4	$11.9	$39.2	$24.3
POVERTY STATUS	16.8%	$710.1	$215.2	$123.3	$15.1	$39.1	$32.7	$239.0	$150.0
Under 100%	16.8%	$290.9	$149.4	$54.6	$6.1	$17.3	$14.1	$84.6	$47.8
101-150%	16.8%	$95.0	$26.3	$23.5	$2.6	$7.5	$6.0	$38.6	$21.8
151-200%	16.8%	$84.4	$9.9	$30.4	$3.4	$9.6	$7.4	$49.9	$28.2
Over 200%	16.8%	$239.9	$29.7	$26.5	$3.0	$8.4	$6.3	$80.8	$45.7

NCSIZE/Costs

NOTE: Figures shown are based on a premium of $75 per month ($900 per year) per full-time worker or spouse and a premium of $46 per month ($550 per year) for child dependents.

ESTIMATING THE NUMBER OF MEDICALLY UNINSURABLE
NORTH CAROLINA, 1986

ESTIMATE	SOURCE OF ASSUMPTIONS/DATA
METHOD 1:	USE STANDARD NATIONAL ASSUMPTIONS
5,601,395	Total Population Under 65 in 1986 (OSBM, 1987)
1.0%	Fraction Uninsurable (Bovbjerg and Koller, 1986)
56,014	Total Estimated Uninsurables
METHOD 2:	USE 1988 OTA SURVEY OF HEALTH INSURERS (MINIMUM ESTIMATE)
6,331,288	Total Population in 1986 (OSBM, 1987)
69.3%	Fraction with Private Only (estimate, 1985 baseline)
8.0%	Fraction Denied Coverage (OTA, 1988)
20.0%	Annual Turnover Rate (Malhotra, 1980, Table 53)
76,318	Minimum Estimated Uninsurables
METHOD 3:	USE 1988 OTA SURVEY OF HEALTH INSURERS (MAXIMUM ESTIMATE)
6,331,288	Total Population in 1986 (OSBM, 1987)
69.5%	Fraction with Private Only (estimate, 1985 baseline)
10.0%	Fraction Denied Coverage (OTA, 1988)
489,153	Maximum Estimated Uninsurables
METHOD 4:	USE 1984 NEW MEXICO POPULATION SURVEY
896,400	Total N.C. Uninsured in 1986 (SCSIZE model)
5.2%	Fraction Without Coverage Due to Health (Wombold et al., 1984)
46,613	Total Estimated Uninsurables
METHOD 5:	USE 1986 OREGON POPULATION SURVEY
896,400	Total N.C. Uninsured in 1986 (SCSIZE model)
2.0%	Fraction Without Coverage Due to Health (Oregon, 1988)
17,928	Total Estimated Uninsurables
METHOD 6:	USE 1984-1986 COMMUNICATING FOR AGRICULTURE SURVEY OF 5 STATES
2,340,000	Total Households, 1986 (Census, 1987c)
10.0%	Fraction with Someone Denied Coverage Due to Health (Trippler, 1987, p. 379)
234,000	Total Estimated Uninsurables
METHOD 7:	INCLUDE ALL UNINSURED WHO ARE DISABLED/ACTIVITY-LIMITED
503,200	Total Children Under 6
1.6%	Prevalence of physical/mental disabilities (Census, 1986b)
110.6%	NC % of Persons >3 With Limiting Health Condition Compared to U.S. (SIE, unpubli
19.2%	Uninsured Rate Among All Children <6 (SCSIZE model)
105.9%	Relative Uninsured Rate, Children with Activity Limitations vs. All Children 3-1
1,813	Subtotal Uninsurables Under 6
1,115,000	Total Children 6 to 17
1.6%	Prevalence of physical/mental disabilities (Census, 1986b)
110.6%	NC % of Persons >3 With Limiting Health Condition Compared to U.S. (SIE, unpubli
16.1%	Uninsured Rate Among All Children 6 to 17 (SCSIZE model)
105.9%	Relative Uninsured Rate, Children with Activity Limitations vs. All Children 3-1
3,369	Subtotal Uninsurables 6 to 17
3,983,200	Total Adults 18-64
5.7%	Fraction Prevented from Working Due to Disability (NC figures from Census, 1985)
15.4%	Uninsured Rate Among All Adults 18 to 64 (SCSIZE model)
129.7%	Relative Uninsured Rate, Work Disabled Adults vs. All Adults 18 to 64 (1986 SIPP
45,419	Subtotal Uninsurables 18 to 64
50,601	Total Estimated Uninsurables
SUMMARY:	SUMMARY OF METHODS #1-#7
138,661	Average of All Methods
92,709	Trimmed Mean (Excludes lowest and highest estimates)
253,540	Average of High & Low

Table A-2

AVERAGE DAILY HEALTH INSURANCE STATUS OF POPULATION
NORTH CAROLINA, 1986
(All Figures in Thousands)

INSURANCE STATUS ON AVERAGE DAY, BY AGE	ALL PERSONS	POVERTY STATUS OF FAMILIES <75 %	<100 %	<125 %	<133 %	<150 %	<175 %	<200 %	>200 %
					(000's)				
UNDER 6	503.2	94.0	135.9	163.8	173.9	195.5	230.8	265.5	237.7
Medicaid	68.5	43.7	53.5	56.5	57.6	59.9	63.7	67.4	1.1
Categorically Needy	64.3	41.7	51.1	53.9	54.9	57.1	60.7	64.3	0.0
Medically Needy	4.2	2.0	2.5	2.6	2.6	2.8	2.9	3.1	1.1
Medicare	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Public Coverage	68.5	43.7	53.5	56.5	57.6	59.9	63.7	67.4	1.1
Private Only Coverage	338.1	11.2	28.5	46.6	53.5	68.2	94.6	120.6	217.5
Uninsured	96.7	39.2	53.9	60.7	62.8	67.3	72.5	77.5	19.1
6 THROUGH 17	1,115.0	157.4	234.2	282.4	297.1	328.5	413.0	492.2	622.8
Medicaid	91.5	57.8	72.2	75.5	76.6	78.7	84.6	90.0	1.4
Categorically Needy	85.4	54.8	68.5	71.6	72.6	74.6	80.2	85.4	0.0
Medically Needy	6.1	3.0	3.7	3.9	4.0	4.1	4.4	4.7	1.4
Medicare	1.7	0.5	0.7	0.8	0.9	0.9	1.0	1.1	0.6
Total Public Coverage	92.4	58.0	72.5	76.0	77.0	79.2	85.1	90.7	1.7
Private Only Coverage	843.0	30.8	66.2	99.4	110.6	134.3	201.7	264.8	578.2
Uninsured	179.7	68.6	95.4	106.9	109.5	114.9	126.2	136.8	42.9
18 THROUGH 64	3,983.2	303.4	445.8	602.4	655.5	768.3	979.8	1,204.9	2,778.3
Medicaid	108.3	57.9	69.1	76.8	79.5	85.0	95.5	106.6	1.7
Categorically Needy	96.3	52.3	62.4	69.4	71.8	76.8	86.2	96.3	0.0
Medically Needy	12.0	5.6	6.7	7.4	7.7	8.2	9.2	10.3	1.7
Medicare	91.6	15.4	22.6	30.7	32.7	37.0	44.8	51.4	40.2
Total Public Coverage	179.3	66.6	82.0	102.6	106.9	116.1	133.0	149.7	35.4
Private Only Coverage	3,189.6	68.1	134.3	221.8	259.2	338.5	497.5	667.9	2,515.8
Uninsured	614.3	168.6	229.4	278.0	289.4	313.7	349.3	387.3	227.0
65 AND OVER	729.9	83.9	161.5	223.7	241.1	277.9	326.0	369.8	360.1
Medicaid	57.8	21.4	41.1	45.8	47.1	49.9	53.5	56.9	0.9
Categorically Needy	34.7	21.4	41.1	45.8	47.1	49.9	53.5	56.9	0.0
Medically Needy	23.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9
Medicare	704.6	80.7	155.4	215.5	232.3	267.9	314.4	356.7	347.9
Total Public Coverage	706.5	80.8	155.7	217.9	234.8	270.5	317.2	359.6	347.9
Private Only Coverage	17.7	0.6	3.3	2.6	3.0	3.8	5.0	6.1	10.5
Uninsured	5.7	2.4	2.5	3.2	3.3	3.6	3.8	4.1	1.6
TOTAL	6,331.3	638.7	977.4	1,272.2	1,367.6	1,570.1	1,949.7	2,332.4	3,998.9
Medicaid	325.9	180.6	236.0	254.7	260.7	273.6	297.3	320.9	5.1
Categorically Needy	280.6	170.0	223.1	240.8	246.4	258.5	280.7	302.8	0.0
Medically Needy	45.3	10.6	12.9	14.0	14.3	15.1	16.6	18.1	5.1
Medicare	797.9	96.6	178.8	247.1	265.9	305.8	360.2	409.2	388.6
Total Public Coverage	1,046.6	249.1	363.8	453.0	476.3	525.7	599.0	667.4	386.2
Private Only Coverage	4,388.3	110.7	232.3	370.4	426.3	544.9	798.8	1,059.3	3,322.0
Uninsured	896.4	278.8	381.3	448.8	465.0	499.5	551.8	605.6	290.8

12-Jun-89

SCSIZE/1986Fop

Table A-3

ANNUAL NUMBER OF MEDICALLY INDIGENT "AT RISK"
NORTH CAROLINA, 1986
(All Figures in Thousands)

INSURANCE STATUS ON AVERAGE DAY, BY AGE	ALL PERSONS	POVERTY STATUS OF FAMILIES <75 %	<100 %	<125 %	<133 %	<150 %	<175 %	<200 %	>200 %
ANNUAL MEDICALLY INDIGENT "AT RISK"	1,890.8	421.7	649.3	788.5	839.5	947.9	1,055.8	1,174.2	716.5
ANNUAL UNINSURED	1,149.8	321.8	449.1	519.5	545.3	600.0	651.6	714.5	435.3
Uninsured All Year	669.8	216.0	300.3	351.6	362.7	386.2	423.1	464.2	205.6
Uninsured Part Year	480.0	105.8	148.8	167.9	182.6	213.8	228.5	250.3	229.6
ANNUAL UNDERINSURED	741.0	99.9	200.2	269.0	294.2	347.9	404.2	459.7	281.3
Underinsured Private	464.5	61.5	129.1	178.0	197.7	239.7	278.4	318.0	146.5
Underinsured Medicare	276.5	38.4	71.1	91.0	96.5	108.2	125.8	141.7	134.8
HIGH RISK GROUPS									
Catastrophically Ill	270.9	136.8	179.8	202.8	208.7	221.3	239.0	245.0	25.9
Medically Uninsurable	106.0	46.3	69.4	78.8	79.7	81.6	84.4	86.2	13.8
MEDICALLY INDIGENT SHARE									
"At Risk"	20.9%	49.9%	52.7%	50.6%	50.5%	50.4%	45.5%	42.5%	17.8%
At Risk/Medicaid	2.9%	16.1%	13.8%	11.4%	10.9%	9.9%	8.7%	7.8%	0.1%
Annual Medicaid	4.1%	22.7%	16.9%	16.0%	15.3%	14.0%	12.2%	11.0%	0.1%
Insured "Low Risk"	66.0%	11.3%	16.6%	22.0%	23.3%	25.7%	33.6%	38.6%	82.0%

SCSIZE/BeAtRisk 1.2 12-Jun-89

Table B-1

CHARACTERISTICS OF UNINSURED WORKERS
NORTH CAROLINA, 1986
(All Figures in Thousands)

EMPLOYER CHARACTERISTIC	PERCENT OF TOTAL EMPLOYEES, BY SOURCE OF COVERAGE: Direct Employer Coverage	Indirect Employer Coverage	Other Health Coverage	Uninsured	All Workers	AVERAGE ANNUAL WORKERS IN 1986	PERCENT DISTRIBUTION: All Workers	Uninsured
ALL EMPLOYEES (000's)	1,905.4	360.4	369.5	388.7	3,024.0			
INDUSTRY TOTAL	63.0%	11.9%	12.2%	12.9%	100%	3,024.0	100.0%	100.0%
Personal Services*	27.7%	22.0%	19.4%	30.9%	100%	55.2	1.8%	4.4%
Agriculture	29.7%	23.2%	20.4%	26.8%	100%	78.6	2.6%	5.4%
Construction	57.0%	10.9%	9.3%	22.7%	100%	175.4	5.8%	10.2%
Self-Employed	29.6%	21.8%	26.0%	22.6%	100%	241.9	8.0%	14.1%
Retail Trade	40.8%	23.9%	13.0%	22.2%	100%	393.1	13.0%	22.5%
Entertainment/Rec.*	31.6%	23.2%	23.1%	22.0%	100%	16.7	0.6%	0.9%
Business/Repairs*	50.4%	16.9%	11.2%	21.6%	100%	107.7	3.6%	6.0%
Professional Services*	65.5%	17.0%	7.9%	9.5%	100%	161.4	5.3%	4.0%
Wholesale Trade	75.1%	9.0%	6.6%	9.4%	100%	130.0	4.3%	3.1%
Mining	83.9%	0.0%	7.4%	8.7%	100%	9.1	0.3%	0.2%
Manufacturing	85.8%	5.3%	2.6%	8.3%	100%	870.9	28.8%	18.6%
Transp./Commun.	82.3%	5.7%	4.5%	7.5%	100%	133.1	4.4%	2.6%
Finance/Insurance	74.6%	12.6%	5.6%	7.3%	100%	136.1	4.5%	2.5%
Public Admin.	81.6%	8.2%	4.8%	5.3%	100%	396.1	13.1%	5.4%
*Services Subtotal	52.9%	18.1%	11.6%	17.4%		341.1	11.3%	15.3%
HOURLY EARNINGS AS PERCENT OF MINIMUM WAGE						3,024.0	100.0%	100.0%
Under 100%	17.9%	30.6%	25.7%	25.8%	100%	429.2	14.2%	28.5%
100 to 124%	31.5%	28.5%	17.0%	23.0%	100%	320.0	10.6%	19.0%
125 to 199%	55.5%	19.2%	10.4%	14.9%	100%	894.3	29.6%	34.3%
200 to 399%	80.1%	9.3%	4.6%	6.0%	100%	963.8	31.9%	14.9%
400% or more	89.1%	4.4%	3.4%	3.1%	100%	416.8	13.8%	3.3%
SIZE OF EMPLOYER						3,024.0	100.0%	100.0%
Self-Employed	29.6%	21.8%	26.0%	22.6%	100%	241.9	8.0%	14.1%
Agriculture	29.7%	23.2%	20.4%	26.8%	100%	78.6	2.6%	5.4%
2 to 4	28.0%	29.9%	12.2%	29.9%	100%	113.3	3.7%	8.7%
5 to 9	38.3%	25.5%	10.4%	25.8%	100%	170.3	5.6%	11.3%
10 to 19	55.0%	18.4%	7.5%	19.1%	100%	212.6	7.0%	10.4%
20 to 24	61.2%	15.8%	6.4%	16.6%	100%	54.4	1.8%	2.3%
25 to 49	66.4%	14.6%	5.5%	13.4%	100%	272.1	9.0%	9.4%
50 to 99	73.1%	11.6%	4.4%	10.9%	100%	277.1	9.2%	7.8%
100 to 499	74.7%	12.5%	3.3%	9.5%	100%	648.1	21.4%	15.9%
500 to 999	78.9%	10.8%	2.6%	7.5%	100%	239.9	7.9%	4.6%
1000 or More	84.8%	7.6%	2.0%	5.6%	100%	319.5	10.6%	4.6%
Government	81.6%	8.2%	4.8%	5.3%	100%	396.1	13.1%	5.4%
Under 25 Subtotal	39.3%	22.5%	14.9%	23.3%	100.0%	871.2	28.8%	52.3%
Over 25 Subtotal	76.7%	10.9%	3.7%	8.6%	100.0%	2,152.8	71.2%	47.7%
NET ADJUSTMENT FACTOR:	102.6%			107.6%				
SCWORKER/Employer	1.048							

Table B-2

DISTRIBUTION OF UNINSURED WORKERS, BY SIZE OF FIRM
NORTH CAROLINA, 1986
(All Figures in Thousands)

SIZE OF EMPLOYER & AVAILABILITY OF HEALTH PLAN	NUMBER OF UNINSURED WORKERS Employer Has Plan	Employer No Plan	Total	PERCENT OF UNINSURED WORKERS Employer Has Plan	Employer No Plan	Total	DISTRIBUTION OF UNINSURED WORKERS Employer Has Plan	Employer No Plan
SMALL FIRMS	53.5	149.6	203.2	26%	74%	100%	26%	83%
Self-Employed	0.0	54.7	54.7	0%	100%	100%	0%	30%
Agriculture	7.0	14.0	21.0	33%	67%	100%	3%	8%
2 to 4	4.3	29.7	33.9	13%	87%	100%	2%	16%
5 to 9	14.1	29.8	43.9	32%	68%	100%	7%	16%
10 to 19	22.9	17.6	40.5	57%	43%	100%	11%	10%
20 to 24	5.2	3.9	9.0	57%	43%	100%	2%	2%
LARGE FIRMS	153.6	31.7	185.5	83%	17%	100%	74%	17%
25 to 99	49.8	17.1	66.9	74%	26%	100%	24%	9%
100 to 499	51.9	9.8	61.6	84%	16%	100%	25%	5%
500 and over	52.2	4.9	57.1	91%	9%	100%	25%	3%
TOTAL	207.4	181.3	388.7	53%	47%	100%	100%	100%

[illegible]/Firmsize 13-Jun-89

Table B-3

ESTIMATED DISTRIBUTION OF UNINSURED WORKERS
BY SIZE OF FIRM AND INDUSTRY
NORTH CAROLINA, 1986
(All Figures in Thousands)

Total Employees	Total	Under 5	5-9	10-24	25-99	100-499	500-999	>1000
TOTAL EMPLOYEES (000'S)	3,024.0	433.9	170.3	267.0	549.3	648.1	239.9	715.6
Construction	175.4	20.5	28.0	33.9	50.7	29.1	3.9	9.2
Retail Trade	393.1	33.6	56.4	85.3	164.9	45.3	5.7	1.9
Personal Services	55.2	6.9	6.5	11.3	18.3	10.3	2.0	0.0
Self-Employed	241.9	241.9	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	870.9	5.8	11.4	29.5	119.2	346.4	157.0	201.6
PCT IN FIRMS WITH PLANS	87.7%	49.0%	80.0%	78.0%	92.0%	98.0%	100.0%	100.0%
Construction	76.4%	45.0%	45.0%	67.0%	93.0%	100.0%	100.0%	100.0%
Retail Trade	70.0%	21.0%	21.0%	59.0%	94.0%	96.0%	100.0%	100.0%
Personal Services	48.6%	30.9%	30.9%	49.7%	44.4%	50.7%	52.3%	52.3%
Self-Employed	29.6%	29.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Manufacturing	98.3%	60.0%	60.0%	81.0%	98.0%	100.0%	100.0%	100.0%
IN FIRMS WITH PLANS (000'S)	2,653	213	136	208	505	635	240	716
Construction	134	9	13	23	47	29	4	9
Retail Trade	275	7	12	50	155	43	6	2
Personal Services	24	2	2	6	8	5	1	0
Self-Employed	72	72	0	0	0	0	0	0
Manufacturing	856	3	7	24	117	346	157	202
UNINSURED RATE	12.9%	25.3%	25.8%	18.6%	12.2%	9.5%	7.5%	5.5%
Construction	22.7%	35.4%	36.1%	26.0%	17.1%	13.3%	10.5%	7.7%
Retail Trade	22.2%	34.6%	35.3%	25.4%	16.7%	13.0%	10.2%	7.5%
Personal Services	30.9%	48.7%	49.7%	35.8%	23.4%	18.3%	14.4%	10.5%
Self-Employed	22.6%	22.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Manufacturing	8.3%	22.8%	23.3%	16.8%	11.0%	8.6%	6.7%	4.9%
UNINSURED WORKERS (000'S)	388.7	109.7	43.9	49.6	66.9	61.6	17.9	39.1
Construction	39.8	7.3	10.1	8.8	8.7	3.9	0.4	0.7
Retail Trade	87.4	11.6	19.9	21.7	27.5	5.9	0.6	0.1
Personal Services	17.1	3.3	3.2	4.0	4.3	1.9	0.3	0.0
Self-Employed	54.7	54.7	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	72.3	1.3	2.7	4.9	13.1	29.7	10.6	10.0
PERCENT IN FIRMS W/PLANS	53.3%	10.3%	32.2%	56.7%	74.4%	84.2%	91.5%	91.5%
Construction	35.0%	7.3%	22.8%	40.1%	52.7%	59.6%	64.7%	64.7%
Retail Trade	44.4%	8.7%	27.1%	47.8%	62.8%	71.0%	77.1%	77.1%
Personal Services	72.8%	14.7%	45.9%	80.9%	95.0%	95.0%	95.0%	95.0%
Self-Employed	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Manufacturing	89.9%	11.7%	36.5%	64.3%	84.4%	95.0%	95.0%	95.0%
UNINSURED: FIRMS WITH PLANS	207.4	11.3	14.1	28.1	49.8	51.9	16.4	35.8
Construction	14.0	0.5	2.3	3.5	4.6	2.3	0.3	0.5
Retail Trade	38.8	1.0	5.4	10.4	17.3	4.2	0.5	0.1
Personal Services	12.4	0.5	1.5	3.3	4.1	1.8	0.3	0.0
Self-Employed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	65.0	0.2	1.0	3.2	11.1	28.2	10.1	9.5
UNINSURED: FIRMS W/O PLANS	181.3	98.4	29.8	21.5	17.1	9.8	1.5	3.3
Construction	25.9	6.7	7.8	5.3	4.1	1.6	0.1	0.2
Retail Trade	48.6	10.6	14.5	11.3	10.2	1.7	0.1	0.0
Personal Services	4.6	2.8	1.7	0.8	0.2	0.1	0.0	0.0
Self-Employed	54.7	54.7	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	7.3	1.2	1.7	1.8	2.0	1.5	0.5	0.5

NCWORKER/Detail1

Table B-4

ESTIMATED DISTRIBUTION OF PART-TIME/SEASONAL WORKERS
BY SIZE OF FIRM AND INDUSTRY
NORTH CAROLINA, 1986
(All Figures in Thousands)

Total Employees	Total	Under 5	5-9	10-24	25-99	100-499	500-999	>1000
			Percent of Workers Who Are Part-time					
FIRMS WITH PLANS: PT %	14.1%	20.8%	19.4%	12.2%	12.2%	15.6%	12.2%	12.2%
Construction	20.3%	28.9%	26.9%	17.0%	17.0%	21.6%	17.0%	17.0%
Retail Trade	29.6%	40.0%	37.3%	23.5%	23.5%	29.9%	23.5%	23.5%
Personal Services	40.7%	58.1%	54.2%	34.1%	34.1%	43.4%	34.1%	34.1%
Self-Employed	35.5%	35.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Manufacturing	10.1%	10.1%	9.4%	5.9%	5.9%	7.5%	5.9%	5.9%
FIRMS W/O PLANS: PT %	33.0%	33.7%	28.5%	35.6%	20.0%	66.7%	0.6%	0.6%
Construction	24.9%	28.8%	24.4%	30.4%	17.1%	57.0%	0.5%	0.5%
Retail Trade	42.0%	47.9%	40.6%	50.5%	28.4%	94.8%	0.8%	0.8%
Personal Services	57.8%	61.0%	51.7%	64.4%	36.2%	95.0%	1.0%	1.0%
Self-Employed	35.5%	35.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Manufacturing	23.6%	28.4%	24.1%	30.0%	16.9%	56.3%	0.5%	0.5%
			Percent of Workers Who Are Seasonal					
FIRMS WITH PLANS: SEAS. %	4.7%	1.6%	3.2%	5.6%	5.6%	5.6%	4.4%	4.4%
Construction	11.0%	3.9%	7.7%	13.5%	13.5%	13.5%	10.8%	10.8%
Retail Trade	9.8%	3.5%	6.8%	12.0%	12.0%	12.0%	9.6%	9.6%
Personal Services	6.1%	2.0%	4.0%	7.0%	7.0%	7.0%	5.6%	5.6%
Self-Employed	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Manufacturing	2.4%	2.4%	4.8%	8.4%	8.4%	8.4%	6.7%	6.7%
FIRMS W/O PLANS: SEAS. %	11.9%	8.0%	15.6%	4.0%	36.0%	22.0%	100.0%	100.0%
Construction	19.4%	10.1%	19.8%	5.1%	45.6%	27.9%	100.0%	100.0%
Retail Trade	17.3%	8.8%	17.2%	4.4%	39.6%	24.2%	100.0%	100.0%
Personal Services	10.7%	3.5%	6.8%	1.7%	15.7%	9.6%	100.0%	100.0%
Self-Employed	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Manufacturing	4.3%	1.9%	3.8%	1.0%	8.7%	5.3%	100.0%	100.0%
TOTAL PT WORKERS	496.1	118.8	36.2	46.3	70.6	107.5	29.3	87.5
Construction	37.5	5.9	7.1	7.3	8.6	6.3	0.7	1.6
Retail Trade	123.2	15.5	22.5	29.5	39.2	14.7	1.3	0.4
Personal Services	27.0	4.1	3.4	5.6	6.4	7.1	0.4	0.0
Self-Employed	86.0	86.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	60.4	1.0	1.7	3.1	7.3	26.0	9.3	11.9
TOTAL TEMP/SEASONAL WORKERS	169.2	21.1	9.6	13.9	43.9	38.1	10.7	31.8
Construction	22.5	1.5	4.0	3.6	8.0	3.9	0.4	1.0
Retail Trade	47.6	2.6	8.5	7.6	22.6	5.7	0.5	0.2
Personal Services	5.1	0.2	0.4	0.5	2.2	0.8	1.0	0.0
Self-Employed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	65.8	0.1	0.5	2.1	10.0	29.0	10.5	13.5
Unadjusted Part-time %	15.5%	27.5%	22.2%	16.0%	12.0%	15.0%	11.0%	11.0%
NC/US Adjustment	111.1%							

NCWORKER/Detail2

Table B-5

ESTIMATED DISTRIBUTION OF UNINSURED PART-TIME/SEASONAL WORKERS
BY SIZE OF FIRM AND INDUSTRY
NORTH CAROLINA, 1986
(All Figures in Thousands)

Total Employees	Total	Under 5	5-9	10-24	25-99	100-499	500-999	>1000
FIRMS WITH PLANS: % OF WORKERS NOT ELIGIBLE FOR HI								
Part-time Workers	----	65.0%	65.0%	72.0%	71.0%	77.0%	73.0%	73.0%
Seasonal Workers	----	50.0%	50.0%	49.0%	45.0%	57.0%	67.0%	67.0%
UNCOVERED SEASONAL WORKERS	114.8	19.4	7.5	8.0	28.5	23.0	7.1	21.3
Construction	14.6	1.3	3.5	2.1	4.5	2.2	0.3	0.7
Retail Trade	31.2	2.5	8.1	4.5	12.3	3.4	0.4	0.1
Personal Services	4.3	0.2	0.3	0.3	1.8	0.7	1.0	0.0
Self-Employed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	38.7	0.1	0.3	1.0	4.6	16.6	7.1	9.1
UNINSURED SHARE OF UNCOVERED	42.4%	44.9%	45.1%	45.9%	43.6%	40.5%	38.3%	39.9%
Construction	57.0%	58.6%	58.9%	59.9%	56.9%	52.9%	50.0%	52.1%
Retail Trade	40.5%	41.3%	41.6%	42.3%	40.2%	37.3%	35.3%	36.7%
Personal Services	46.1%	49.0%	49.3%	50.1%	47.6%	44.3%	41.8%	43.6%
Self-Employed	34.7%	34.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Manufacturing	55.2%	61.2%	61.5%	62.5%	59.4%	55.3%	52.2%	54.3%
UNINSURED SEASONAL WORKERS	48.7	8.7	3.4	3.7	12.4	9.3	2.7	8.5
Construction	8.3	0.8	2.1	1.2	2.6	1.2	0.1	0.3
Retail Trade	12.7	1.0	3.4	1.9	4.9	1.3	0.1	0.0
Personal Services	2.0	0.1	0.2	0.1	0.9	0.3	0.4	0.0
Self-Employed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	21.4	0.1	0.2	0.6	2.7	9.1	3.7	4.9
UNCOVERED PT WORKERS	392.1	103.3	26.9	39.2	52.6	84.7	21.4	63.9
Construction	29.9	5.0	6.0	6.2	6.3	4.8	0.5	1.1
Retail Trade	103.3	14.5	21.0	26.2	28.6	11.7	1.0	0.3
Personal Services	24.2	3.7	3.0	5.1	5.6	6.5	0.3	0.0
Self-Employed	60.5	60.5	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	45.9	0.9	1.5	2.7	5.3	20.1	6.8	8.7
UNINSURED RATE PT WORKERS	15.0%	15.9%	15.9%	13.9%	16.4%	12.9%	15.4%	15.4%
Construction	21.1%	22.3%	22.3%	19.5%	23.0%	18.1%	21.6%	21.6%
Retail Trade	20.8%	21.8%	21.8%	19.0%	22.5%	17.7%	21.1%	21.1%
Personal Services	28.5%	30.6%	30.6%	26.8%	31.6%	24.8%	29.7%	29.7%
Self-Employed	14.2%	14.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Manufacturing	13.0%	14.4%	14.4%	12.5%	14.8%	11.6%	13.9%	13.9%
UNINSURED PART-TIME WORKERS	74.5	18.9	5.7	6.4	11.6	13.9	4.5	13.5
Construction	7.9	1.3	1.6	1.4	2.0	1.1	0.1	0.3
Retail Trade	25.7	3.4	4.9	5.6	8.8	2.6	0.3	0.1
Personal Services	7.7	1.3	1.0	1.5	2.0	1.8	0.1	0.0
Self-Employed	12.2	12.2	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	7.8	0.1	0.2	0.4	1.1	3.0	1.3	1.7
UNINSURED PT/SEASONAL	123.2	27.6	9.1	10.1	24.0	23.2	7.2	22.0
Construction	16.3	2.1	3.7	2.7	4.5	2.3	0.3	0.7
Retail Trade	38.3	4.4	8.3	7.5	13.7	3.9	0.4	0.1
Personal Services	9.7	1.4	1.2	1.6	2.9	2.1	0.5	0.0
Self-Employed	12.2	12.2	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	29.2	0.2	0.5	1.0	3.8	12.2	5.0	6.6
Seasonal/Temp Uninsured Adj.	1.08							

NCWORKER/Detail3

Table 8-6

POTENTIAL ACCESS TO COVERAGE THROUGH WORKING FAMILY MEMBERS
NORTH CAROLINA, 1986
(All Figures in Thousands)

POTENTIAL SOURCE OF WORKER COVERAGE	TOTAL FAMILY MEMBERS	PERCENT UNINSURED	TOTAL UNINSURED MEMBERS	PERCENT DISTRI-BUTION	----- DISTRIBUTION BY FAMILY STATUS ----- Family Head	Family Spouse	Child Over 18	Child Under 18	TOTAL
TOTAL UNINSURED	6,331.3	14.2%	896.4	100.0%	32.6%	17.6%	16.3%	33.5%	100.0%
Full-time Worker	4,574.9	10.8%	494.1	55.1%	26.3%	19.0%	21.3%	33.4%	100.0%
Part-time Worker	417.7	31.4%	131.3	14.7%	40.6%	13.8%	14.7%	30.9%	100.0%
Unemployed	203.4	39.6%	80.5	9.0%	37.9%	11.4%	12.4%	38.3%	100.0%
Not in Labor Force	1,135.3	16.8%	190.5	21.3%	41.4%	18.9%	6.0%	33.6%	100.0%
DISTRIBUTION	6,331.3	14.2%	896.4		292.6	157.3	146.1	300.3	896.4
TOTAL UNINSURED POOR	977.4	39.0%	381.3	100.0%	38.3%	12.5%	5.7%	43.5%	100.0%
Full-time Worker	322.6	43.0%	138.8	36.4%	30.3%	16.8%	6.7%	46.2%	100.0%
Part-time Worker	115.7	56.4%	65.3	17.1%	43.5%	12.3%	5.0%	39.2%	100.0%
Unemployed	113.5	46.9%	53.3	14.0%	38.0%	7.2%	8.1%	46.7%	100.0%
Not in Labor Force	425.5	29.1%	124.0	32.5%	44.7%	10.2%	3.8%	41.3%	100.0%
DISTRIBUTION	977.4	39.0%	381.3		146.1	47.8	21.6	165.9	381.3

SCWORKER/Laborf 13-Jun-89

Table C-1

ESTIMATED UNINSURED WORKERS FACING WAITING PERIOD REQUIREMENT
NORTH CAROLINA, 1986
(All Figures in Thousands)

Total Employees	Total	Under 5	5-9	10-24	25-99	100-499	500-999	>1000
AVERAGE WAITING PERIOD		3	3	3	2	2	2	2
ANNUAL TURNOVER RATES W/PLANS		28.8%	21.6%	25.6%	19.5%	19.0%	19.0%	19.0%
Construction	24.8%	32.6%	24.4%	28.9%	22.1%	21.4%	21.4%	21.4%
Retail Trade	22.8%	30.1%	22.6%	26.7%	20.4%	19.8%	19.8%	19.8%
Personal Services	22.2%	29.0%	21.8%	25.8%	19.7%	19.1%	19.1%	19.1%
Self-Employed	20.4%	20.4%	15.3%	18.1%	13.8%	13.4%	13.4%	13.4%
Manufacturing	19.6%	29.1%	21.8%	25.8%	19.7%	19.2%	19.2%	19.2%
DAILY IN WAITING PERIOD	43.5	6.9	3.3	6.1	7.2	8.1	2.9	9.0
Construction	3.7	0.4	0.5	1.0	1.0	0.6	0.1	0.2
Retail Trade	4.7	0.2	0.3	1.4	2.1	0.5	0.1	0.0
Personal Services	0.5	0.1	0.1	0.2	0.1	0.1	0.0	0.0
Self-Employed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing	15.9	0.2	0.2	1.0	2.3	6.1	2.6	3.5
ALTERNATIVE METHOD								
Total Uninsured Adults, 1986	621.7							
Percent in New Job (NCCS)	12.5%							
Total in Waiting Period	77.7							

NCWORKER/Detail3

INDIGENT HEALTH CARE STUDY COMMISSION
SUBCOMMITTEE ON PRIVATE OPTIONS

PRIVATE OPTIONS

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Senator James Johnson

Representative Walter Jones

Commissioner Jim Long

Senator Tony Rand

Ms. Pam Silberman

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Duke University

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Intergovernmental Health Policy Project
George Washington University
Washington, D. C.

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Health Resources Development Section
Division of Facility Services
Department of Human Resources

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Burlington Industries
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Manpower Services
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Mary Duncan
Benefits Manager
York Construction
Raleigh, N.C.

Torq Wade
North Carolina Foundation for Alternative Health Programs, Inc.

Sari Teplin
Consultant
Chapel Hill, N.C.

INFORMATION PRESENTED TO THE PRIVATE OPTIONS SUBCOMMITTEE

Health Care for the Medically Indigent of North Carolina: How to Assist the Working Uninsured

Strategies Employed by Other States to Address Indigent Health Care Problems

Health Insurance Benefits Offered by Selected Employers

A Personal Injury Protection Program

A Community Health Access Program

Insurance Pools for Part-Time/Seasonal Workers, Workers Under Waiting Periods, and Medically Uninsurables

INDIGENT CARE STUDY COMMISSION
DATA APPENDIX

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PREFACE

The Indigent Care Study Commission was created by the North Carolina General Assembly in 1985 and again in 1987 to study the problem of Medical Indigency in North Carolina. The Commission was assisted in its study by Christopher J. Conover of the Center for Health Policy Research and Education at Duke University. This document reproduces some of the data analysis prepared for the Commission by Mr. Conover. It has been reproduced for the benefit of members of the General Assembly and the public who have an interest in the issue of medical indigency.

The Commission wishes to express its appreciation to Mr. Conover for his contribution to this document as well as for his contribution to developing a body of information and knowledge on this important issue.

TABLE OF CONTENTS

HEALTH CARE FOR THE MEDICALLY INDIGENT

Who Are the Medically Indigent

and

Barriers to Access

Presentation to:

INDIGENT HEALTH CARE STUDY COMMISSION

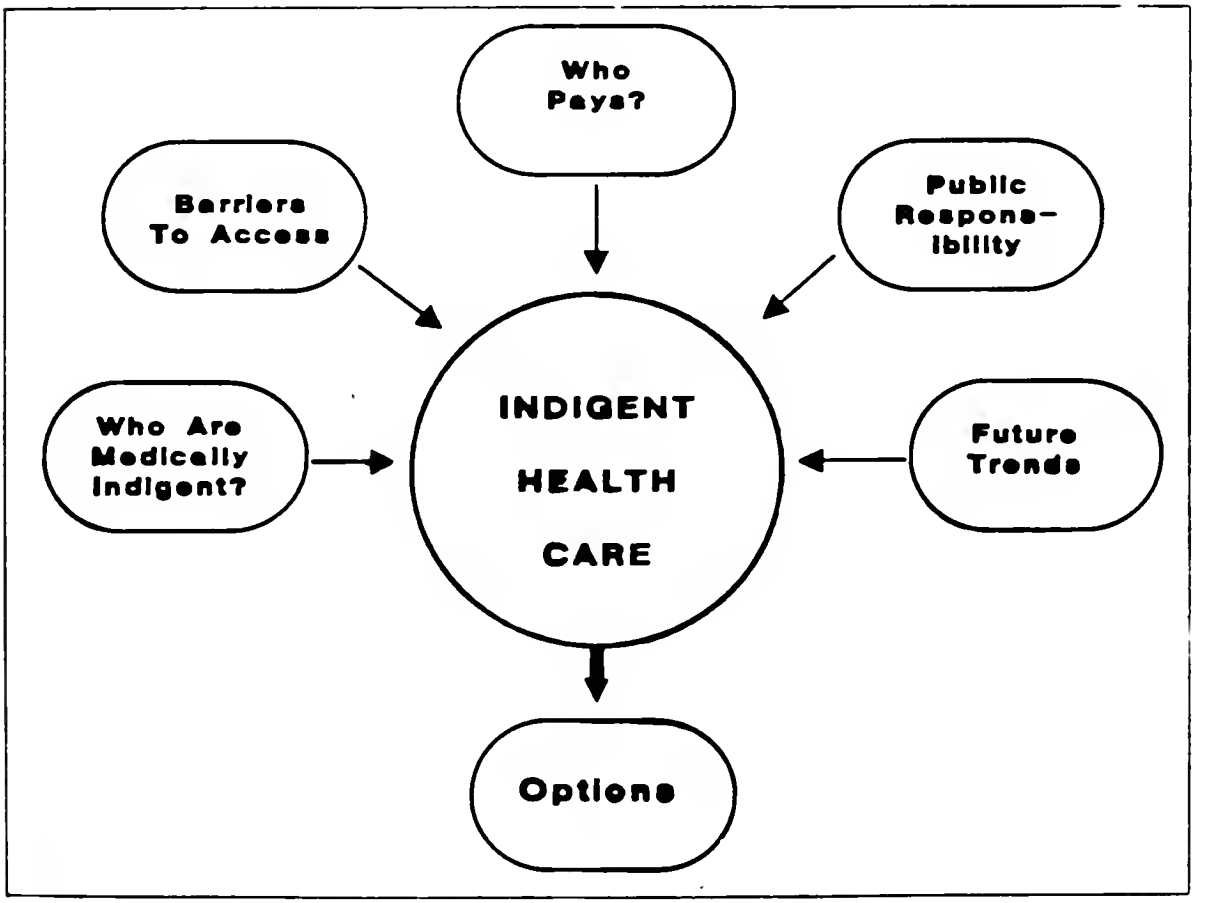
By

Christopher J. Conover
Research Associate
Center for Health Policy Research & Education
Duke University

Duke University
Uninsured Poor Study

- Center for Health Policy Research & Education
- Foundation Funding
- Began February, 1984

Goal: Analyze Policy Options

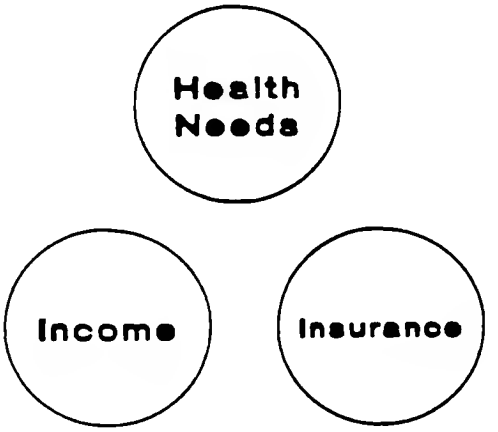


Defining the Medically Indigent

Medically Indigent Cannot

Obtain Adequate Health Care

At Affordable Cost



Center for Health Policy Research & Education

THE UNINSURED POPULATION

AGE CATEGORY	AVERAGE DAILY UNINSURED	ALWAYS UNINSURED	SOME-TIMES UNINSURED	ANNUAL UNINSURED
Under 6	92,000	60,000	86,000	146,000
6 to 17	208,000	143,000	127,000	270,000
18 to 29	268,000	194,000	155,000	349,000
30 to 49	153,000	117,000	93,000	210,000
50 to 64	138,000	100,000	64,000	165,000
65 and over	13,000	10,000	8,000	17,000
TOTAL	872,000	624,000	532,000	1,156,000
		Rate of Being Uninsured		
Under 6	18.2 %	12.0 %	17.0 %	29.0 %
6 to 17	19.1	13.1	11.6	24.7
18 to 29	19.8	14.3	11.4	25.8
30 to 49	9.1	7.0	5.5	12.6
50 to 64	15.5	11.3	7.3	18.6
65 and over	1.9	1.4	1.1	2.5
TOTAL	14.1	10.1	8.6	18.7

NOTE: All figures rounded to the nearest thousand. Figures may not add to totals due to rounding. Average daily uninsured computed based on average rate of being uninsured within each age category using 5 years of data. These rates were applied to the estimated North Carolina population as of July, 1985.
Always uninsured refers to persons without health coverage for the entire year. Sometimes uninsured includes persons with coverage only part of the year. Estimates of always and sometimes uninsured are based on Fall, 1982 North Carolina Citizens Survey and National Medical Care Expenditure Survey from the South.

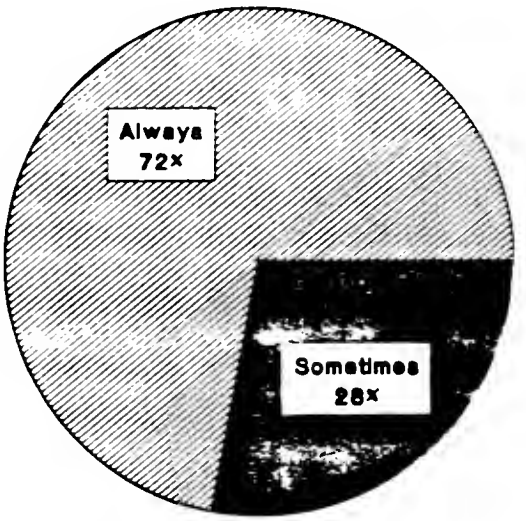
SOURCES: Bureau of the Census, CURRENT POPULATION SURVEY, Annual Demographic File, 1980, 1982, 1983, 1984, 1985 (North Carolina data only).

Office of State Budget and Management, NORTH CAROLINA POPULATION PROJECTIONS. Raleigh: April, 1984.

Office of State Budget and Management, NORTH CAROLINA CITIZEN SURVEY, Fall, 1982.

National Center for Health Services Research, NATIONAL MEDICAL CARE EXPENDITURE SURVEY, unpublished tabulations.

The Uninsured Population



870,000 Daily Uninsured

1,150,000 Annual Uninsured

THE UNDERINSURED POPULATION

MEASURE OF UNDERINSURANCE	FAMILY INCOME AS PERCENT OF POVERTY < 125%	125-200%	200-400%	Over 400%
Percent With Out of Pocket Expenses (1977 $) in Excess of:				
$1000	27.0	18.0	16.8	16.7
2000	16.3	9.4	7.6	8.1
5000	5.3	3.1	2.9	3.0
Percent Who Pay Over 10% of Annual Family Income Out of Pocket for Health*	15.9	2.5	0	0
Percent With 5% Chance of Having Out of Pocket Costs Over 10% of Income	48.2	13.2	5.2	2.3

NOTE: All percentages refer to the percent of privately insured persons below age 65. Those who are covered only by public insurance (such as Medicare) who are underinsured according to the above definitions are not included in the table.

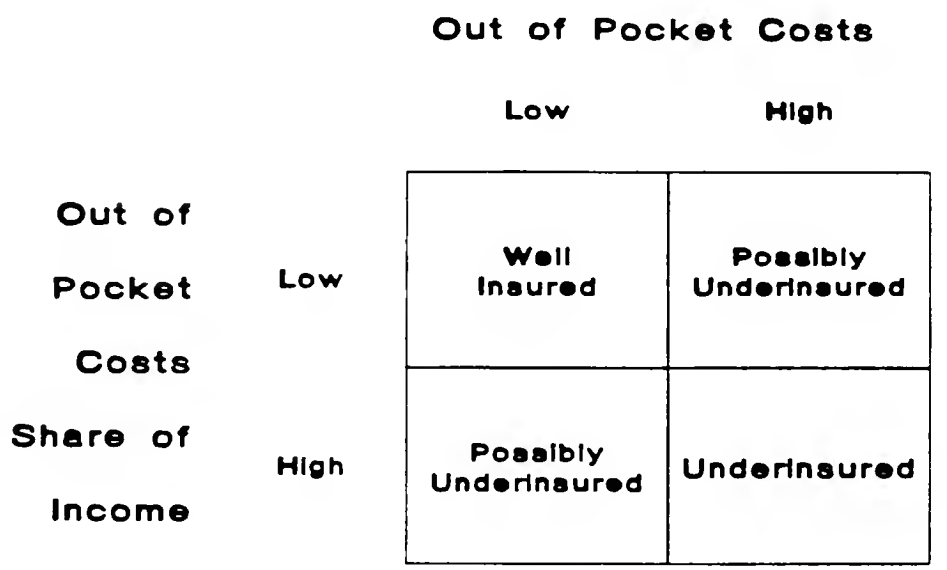
SOURCE: Pamela J. Farley, "Who Are the Underinsured?" Paper presented at the 1984 meeting of the American Public Health Association, Anaheim, California, November 13, 1984.

OUT OF POCKET EXPENDITURES AS A PERCENT OF INCOME FOR ELDERLY HOUSEHOLDS, 1986

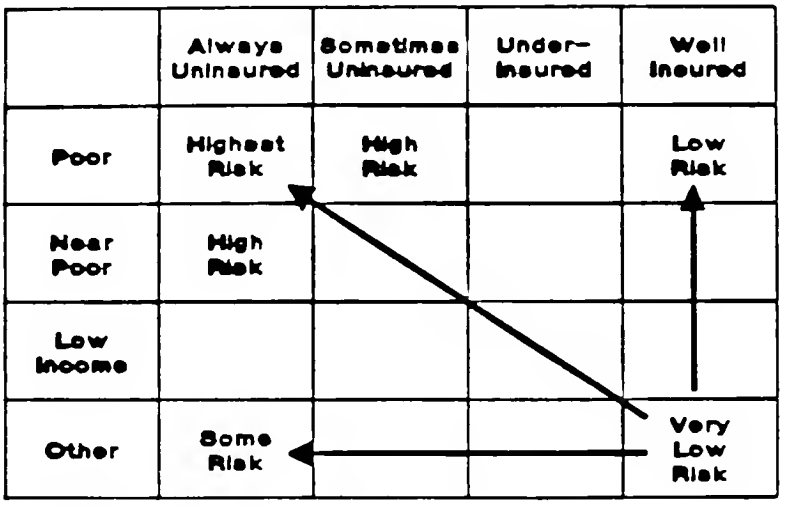
HOUSEHOLD INCOME AS PERCENT OF POVERTY LEVEL	OUT OF POCKET EXPENSES AS PERCENT OF INCOME Medical Costs	Insurance Premiums	Total
Under 125 percent	73 %	9 %	82 %
125-150 percent	18	5	23
150-175 percent	8	6	14
175-200 percent	8	5	13
200-400 percent	8	4	12
Over 400 percent	3	2	5

SOURCE: ICF Incorporated, THE ROLE OF MEDICARE IN FINANCING THE HEALTH CARE OF OLDER AMERICANS. Washington, D.C.: ICF Inc., July, 1985.

The Underinsured Population



Risks of Medical Indigency



NUMBER OF MEDICALLY INDIGENT AT RISK

RISK CATEGORY	TOTAL	FAMILY INCOME AS PERCENT OF POVERTY < 100%	101-150%	151-200%	Over 200%
UNINSURED					
Always Uninsured	626,000	287,000	124,000	121,000	94,000
Sometimes Uninsured	530,000	228,000	79,000	91,000	132,000
UNDERINSURED					
Private Coverage	4,450,000	222,000	363,000	578,000	3,286,000
	x	x	x	x	x
Percent Underinsured	10.9 %	48.2 %	48.2 %	13.2 %	3.8 %
	=	=	=	=	=
Private Underinsured	483,000	107,000	175,000	76,000	126,000
	+	+	+	+	+
Medicare Only	267,000	70,000	40,000	33,000	123,000
	=	=	=	=	=
Total Underinsured	750,000	177,000	215,000	109,000	248,000
TOTAL AT RISK	1,900,000	691,000	419,000	321,000	475,000

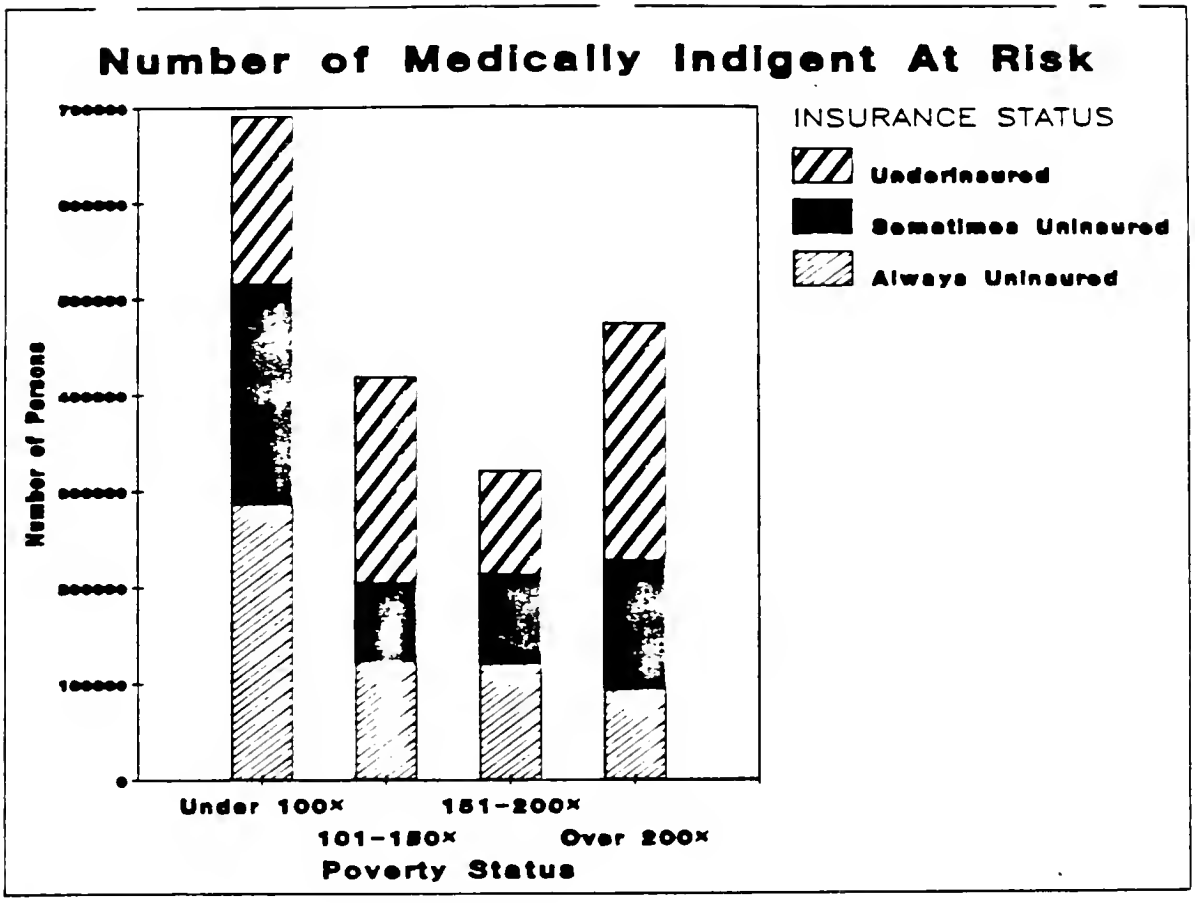
NOTE: All figures rounded to the nearest thousand. Figures may not add to totals due to rounding.

Always Uninsured refers to individuals without any form of health insurance coverage during the entire year. Sometimes Uninsured have coverage only part of the year. Underinsured is defined as having a 5 percent chance of spending more than 10 percent of income out of pocket on health expenses. Percent of privately insured who are at risk obtained from Farley. It is assumed that all persons with Medicare only coverage are underinsured. Figures on number of uninsured and those with private and Medicare coverage are based on 1980-1985 Current Population Survey data for North Carolina. Average rates of having each type of coverage were applied to the estimated population of North Carolina as of July, 1985.

SOURCE: Pamela J. Farley, "Who Are the Underinsured?" Paper presented at the 1984 meeting of the American Public Health Association, Anaheim, California, November 13, 1984.

Bureau of the Census, CURRENT POPULATION SURVEY, Annual Demographic File, 1980, 1982, 1983, 1984, 1985 (North Carolina data only).

Office of State Budget and Management, NORTH CAROLINA POPULATION PROJECTIONS. Raleigh: April, 1984.


Number of Medically Indigent At Risk
INSURANCE STATUS
Underinsured
Sometimes Uninsured
Always Uninsured
Number of Persons
Under 100%
101-150%
151-200%
Over 200%
Poverty Status

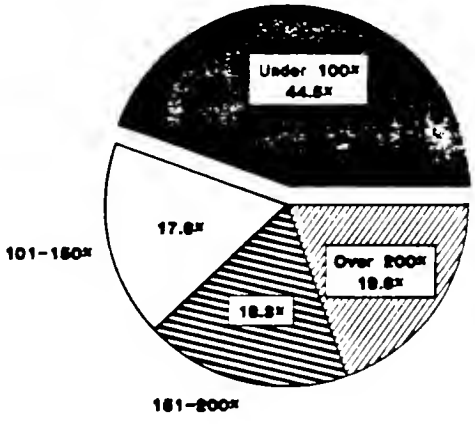
POVERTY STATUS OF MEDICALLY INDIGENT

RISK CATEGORY	TOTAL	FAMILY INCOME AS PERCENT OF POVERTY < 100%	101-150%	151-200%	Over 200%
Always Uninsured	626,000	287,000	124,000	121,000	94,000
Sometimes Uninsured	530,000	228,000	79,000	91,000	132,000
Underinsured	750,000	177,000	215,000	109,000	248,000
TOTAL AT RISK	1,900,000	691,000	419,000	321,000	475,000
		Percent Distribution			
Always Uninsured	100 %	46 %	20 %	19 %	15 %
Sometimes Uninsured	100	43	15	17	25
Underinsured	100	24	29	15	33
TOTAL	100	36	22	17	25
		Percent Distribution			
Always Uninsured	33 %	41 %	38 %	30 %	20 %
Sometimes Uninsured	28	33	28	19	28
Underinsured	39	26	34	51	52
TOTAL	100	100	100	100	100

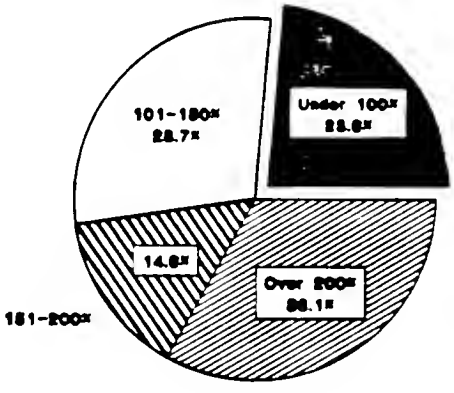
NOTE: All figures rounded to the nearest thousand. All percentages rounded to nearest percent. Figures may not add to totals due to rounding. Underinsured is defined as having a 5 percent chance of spending more than 10 percent of income out of pocket on health expenses. Percent of privately insured who are at risk obtained from Farley. It is assumed that all persons with Medicare only coverage are underinsured. Figures on private and Medicare coverage are based on 1980-1985 Current Population Survey data for North Carolina.

SOURCE: Pamela J. Farley, "Who Are the Underinsured?" Paper presented at the 1984 meeting of the American Public Health Association, Anaheim, California, November 13, 1984.

Poverty Status of Medically Indigent



1,150,000 Annual Uninsured



750,000 Annual Underinsured

LACK OF INSURANCE TRENDS, NORTH CAROLINA, 1980-1985

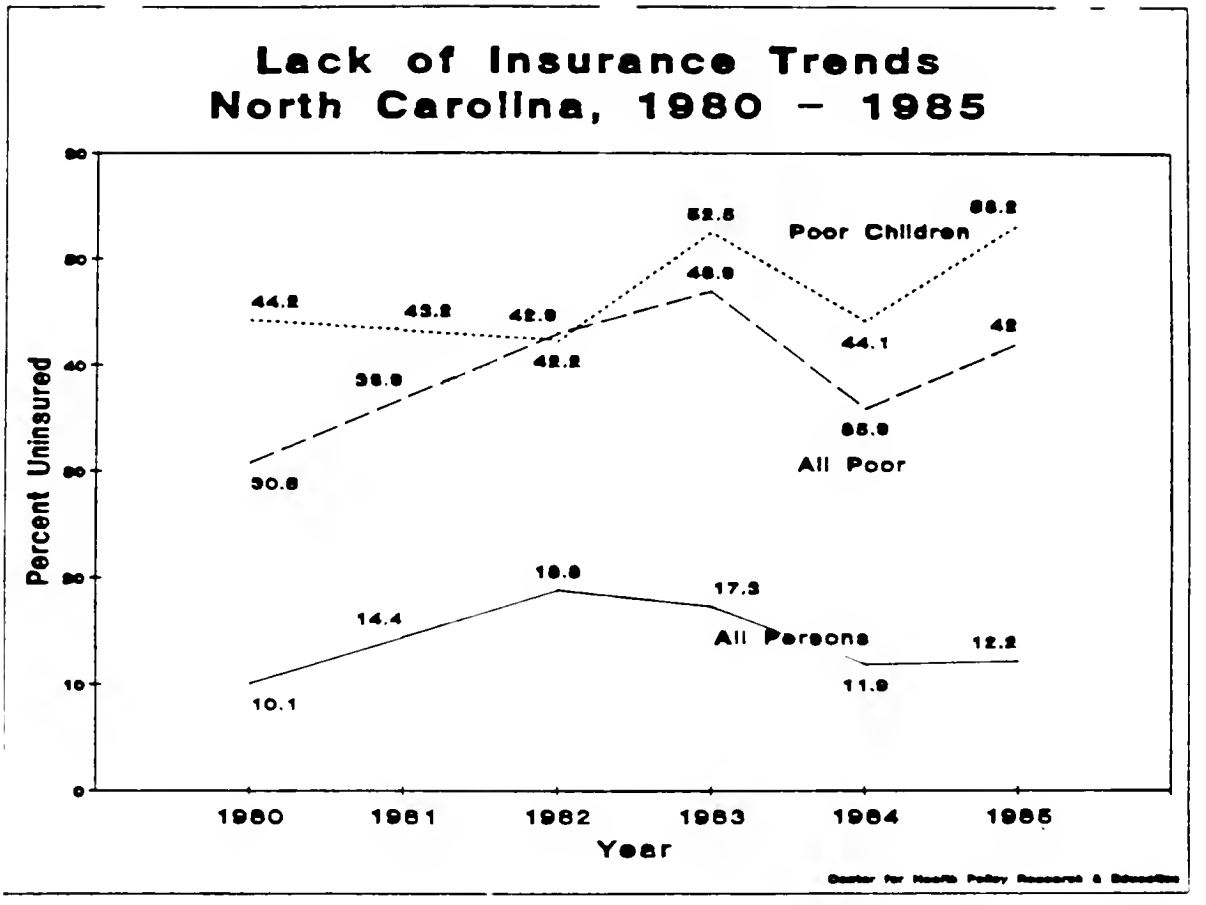
AGE CATEGORY	AVERAGE SAMPLE SIZE	YEAR OF SURVEY 1980	1982	1983	1984	1985
		Percent Without Health Insurance				
CHILDREN UNDER 18						
Below Poverty	143	44.2	42.2	52.5	44.1	53.2
All Persons	858	14.4	21.4	23.7	16.4	18.1
ADULTS 18-64						
Below Poverty	170	27.4	56.0	55.9	40.8	43.8
All Persons	2,022	9.3	20.9	17.4	12.2	11.7
ELDERLY						
Below Poverty	35	7.7	4.5	4.7	0.0	8.5
Above Poverty	341	4.7	0.8	1.9	0.3	1.9
TOTAL						
Below Poverty	348	30.8	42.9	46.9	35.9	42.0
All Persons	3,221	10.1	18.8	17.3	11.9	12.2

NOTE: All figures shown based on March Current Population Survey. Figures shown are the percent of persons who had no health insurance coverage on the day of the survey. Health insurance coverage includes group health coverage, private health coverage, Medicare, Medicaid, and CHAMPUS. Data on group coverage were adjusted upwards slightly due to underreporting of private health coverage. Figures shown assume private health coverage is underreported by 4.1 percent. This is identical to an adjustment used by Congressional Budget Office in its analysis of 1976 Survey of Income and Education data. Data from 1981 do not allow the rate of being uninsured to be computed. In the diagram, therefore, the 1981 figure is estimated by averaging the 1980 and 1982 figures.

CAUTION: Sample sizes for certain age categories are small. Some of the variation observed from year to year is due to sampling, so minor fluctuations are not statistically significant.

SOURCES: Bureau of the Census, CURRENT POPULATION SURVEY, Annual Demographic File, 1980, 1982, 1983, 1984, 1985 (North Carolina data only).

Congressional Budget Office, PROFILE OF HEALTH CARE COVERAGE: THE HAVES AND HAVE-NOTS. Washington, D.C.: March, 1979.


Lack of Insurance Trends
North Carolina, 1980 - 1985
Percent Uninsured
Year
1980
1981
1982
1983
1984
1985
44.2
43.2
42.8
52.6
44.1
55.2
Poor Children
30.6
38.8
42.2
46.8
35.8
42
All Poor
10.1
14.4
18.8
17.3
11.9
12.2
All Persons

COVERAGE TRENDS AMONG POOR, NORTH CAROLINA, 1980-1985

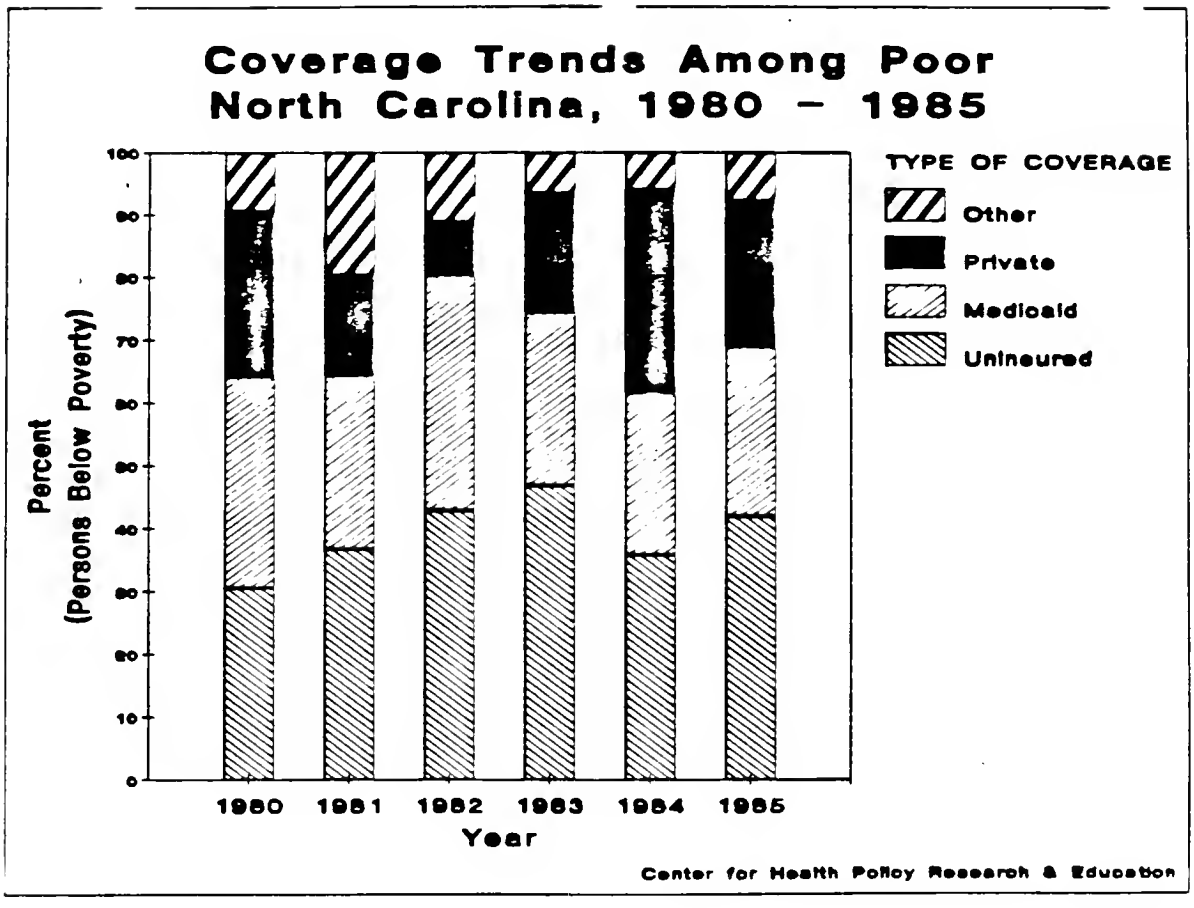
AGE CATEGORY	YEAR OF SURVEY					
	1980	1981	1982	1983	1984	1985
	Percent Without Health Insurance					
Children Under 18	44.2	---	42.2	52.5	44.1	53.2
Adults 18-64	27.4	---	56.0	55.9	40.8	43.8
65 and over	7.7	---	4.5	4.7	0.0	8.5
TOTAL	30.8	---	42.9	46.9	35.9	42.0
	Percent With Private Coverage					
Children Under 18	14.8	15.4	8.5	14.2	23.1	16.2
Adults 18-64	36.1	21.7	11.2	23.2	39.1	29.8
65 and over	25.9	0.0	0.0	19.1	34.8	21.0
TOTAL	26.4	16.0	8.5	19.1	32.4	23.3
	Percent With Medicaid Coverage					
Children Under 18	41.1	42.9	51.8	36.4	35.9	30.7
Adults 18-64	31.0	15.8	31.7	22.1	21.7	24.3
65 and over	23.0	25.3	19.3	21.7	12.1	25.3
TOTAL	33.6	27.6	37.5	27.5	25.7	26.9

NOTE: All figures shown based on March Current Population Survey. Figures shown are the percent of persons who had no health insurance coverage on the day of the survey. Health insurance coverage includes group health coverage, private health coverage, Medicare, Medicaid, and CHAMPUS. Data on group coverage were adjusted upwards slightly due to underreporting of private health coverage. Figures shown assume private health coverage is underreported by 4.1 percent. This is identical to an adjustment used by Congressional Budget Office in its analysis of 1976 Survey of Income and Education data. Data from 1981 do not allow the rate of being uninsured to be computed. In the diagram, therefore, the 1981 figure is estimated by averaging the 1980 and 1982 figures.

CAUTION: Sample sizes for certain age categories are small. Some of the variation observed from year to year is due to sampling, so minor fluctuations are not statistically significant.

SOURCES: Bureau of the Census, CURRENT POPULATION SURVEY, Annual Demographic File, 1980, 1982, 1983, 1984, 1985 (North Carolina data only).

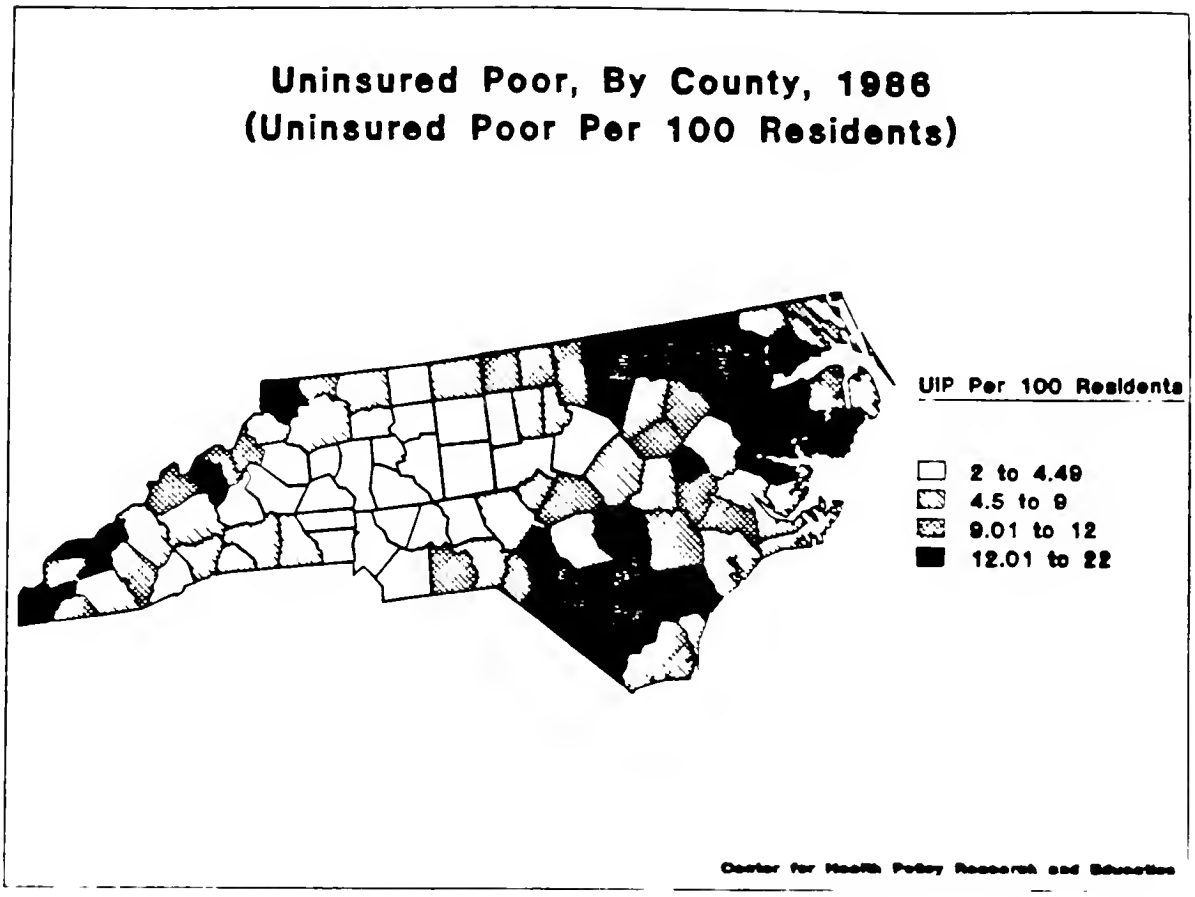
Congressional Budget Office, PROFILE OF HEALTH CARE COVERAGE: THE HAVES AND HAVE-NOTS. Washington, D.C.: March, 1979.


Coverage Trends Among Poor
North Carolina, 1980 – 1985
Percent
(Persons Below Poverty)
100
90
80
70
60
50
40
30
20
10
0
1980
1981
1982
1983
1984
1985
Year
TYPE OF COVERAGE
Other
Private
Medicaid
Uninsured
Center for Health Policy Research & Education

GEOGRAPHIC LOCATION OF THE MEDICALLY INDIGENT

CHARACTERISTIC	UNINSURED	MEDICARE ONLY	PRIVATE ONLY	COMBINED COVERAGE	MEDICAID ENROLLED
REGION					
Mountain	12 %	15 %	12 %	13 %	14 %
Piedmont	36	49	52	48	46
Coastal Plain	40	25	27	26	30
Coast	12	11	9	12	10
COMMUNITY SIZE					
Under 2,500	58	62	60	59	51
2,500 to 9,999	9	13	8	8	9
10,000 to 49,999	16	14	20	12	15
50,000 or more	17	10	12	21	24
SMSA STATUS					
Lives in central city	15	16	16	24	31
Lives in balance of SMSA	22	17	16	17	10
Lives outside SMSA	63	67	69	59	59
PERCENT LIVING ON FARM	5	4	9	9	3

SOURCE: Bureau of the Census, CURRENT POPULATION SURVEY, Annual Demographic File, 1980, 1982, 1983, 1984, 1985 (North Carolina data only).



NOTE: County of residence is not reported on the Current Population Survey. Estimates of the distribution of uninsured poor within the state have been reported in Blakely, et al. (1986) based on North Carolina Citizens Survey data for 1977, 1979, 1981, 1982, 1983, 1984. Due to the sampling frame used in the NCCS, the estimated number of uninsured poor is probably low. Therefore, the NCCS estimates for each HSA were adjusted upwards by 75 percent to account for the difference in the total number of uninsured poor persons using NCCS and the number estimated using the Current Population Survey. Figures shown in the diagram are these adjusted figures.

SOURCES: Eleanor Blakely, Terry Cobb-Wall, James Ellis, Archie Ervin, Heidi Gelzer, Susan Gower, Laura McVey, Deborah Nelson, Margo Price, Thomas Ricketts, Kit Simpson, Steven Wayling, Carol Weissert, and Marion White, GEOGRAPHIC DISTRIBUTION OF THE MEDICALLY UNINSURED POOR AND OF INPATIENT CARE PATTERNS IN NORTH CAROLINA. Report prepared by students in graduate seminar in public policy analysis taught by Duncan MacRae, Jr. and Glenn Wilson, March, 1986.

DEMOGRAPHIC CHARACTERISTICS OF THE MEDICALLY INDIGENT

CHARACTERISTIC	UNINSURED	MEDICARE ONLY	PRIVATE ONLY	COMBINED COVERAGE	MEDICAID ENROLLED
AGE	100 %	100 %	100 %	100 %	100 %
Under 6	15	0	5	0	22
6 to 17	30	0	11	2	29
18 to 29	23	2	26	13	13
30 to 49	18	9	29	13	14
50 to 64	11	18	22	8	6
65 and over	2	71	6	55	16
MALES	47	34	53	42	34
White	24	24	40	24	12
Black	20	10	10	17	21
Other	3	0	3	2	1
FEMALES	53	66	47	58	66
White	25	33	28	34	24
Black	25	33	17	22	40
Other	3	0	3	1	2
RACE	100 %	100 %	100 %	100 %	100 %
White	49	57	68	58	36
Black	45	33	27	39	61
Other	6	10	5	3	3

	Persons Without Health Insurance Coverage		
	Children	Adults	Elderly
White Males	24 %	24 %	20 %
Black Males	22	18	31
White Females	20	29	22
Black Females	26	26	27
Other	8	3	0
TOTAL	100	100	100
White	45	53	42
Female	50	58	49

	Rate of Being Uninsured*		
	Children	Adults	Elderly
White Males	56.8 %	51.2 %	8.2 %
Black Males	38.5	63.7	14.4
White Females	59.2	52.6	3.2
Black Females	42.1	37.5	4.3

* Rates have not been adjusted downward to account for underreporting of private coverage, hence they are slightly higher than actual rates.

SOURCES: Bureau of the Census, CURRENT POPULATION SURVEY, Annual Demographic File, 1980, 1982, 1983, 1984, 1985 (North Carolina data only).

Demographic Characteristics of the Medically Indigent

- Young
- Female
- Nonwhite children
- White adults

FAMILY CHARACTERISTICS OF THE MEDICALLY INDIGENT

CHARACTERISTIC	UNINSURED	MEDICARE ONLY	PRIVATE ONLY	COMBINED COVERAGE	MEDICAID ENROLLED
FAMILY LIVING SITUATION	100 %	100 %	100 %	100 %	100 %
Member of family	69	47	73	69	72
Member of related subfamily	15	6	13	9	20
Member of unrelated subfamily	1	0	0	0	1
Unrelated individual	8	2	6	5	1
Nonfamily householder	6	45	9	17	6
FAMILY STATUS OF CHILDREN	100	100	100	100	100
Lives with both parents	44	NA	67	30	11
Lives with single parent	46	NA	33	60	86
Lives with no parents	10	NA	0	10	3
MARITAL STATUS OF ADULT MALES	100	100	100	100	100
Married	43	62	69	73	38
Widowed	3	14	3	8	18
Divorced/separated	16	10	6	6	14
Never married	38	14	22	13	31
MARITAL STATUS OF ADULT FEMALES	100	100	100	100	100
Married	39	30	52	39	12
Widowed	14	53	11	42	18
Divorced/separated	24	12	17	8	31
Never married	23	5	20	11	39
FAMILY LIVING SITUATION	Percent Distribution by Source of Coverage				
Member of family	37	4	17	10	32
Member of related subfamily	37	2	14	6	41
Member of unrelated subfamily	69	0	0	0	31
Unrelated individual	61	2	18	10	8
Nonfamily householder	23	26	14	17	20
FAMILY STATUS OF CHILDREN	Percent Distribution by Source of Coverage				
Lives with both parents	54	0	28	6	13
Lives with single parent	30	0	8	6	56
Lives with no parents	68	0	0	11	21
MARITAL STATUS	Percent Distribution by Source of Coverage				
Married males	28	10	48	5	9
Married females	31	9	47	5	9
Widowed males	15	21	19	5	41
Widowed females	21	28	18	10	24
Divorced/separated males	51	8	22	2	17
Divorced/separated females	30	6	25	37	28
Never married males	48	4	31	2	15
Never married females	27	2	27	2	42
HOUSEHOLD AND FAMILY SIZE					
Average Household Size-Children	5.0	NA	5.4	4.4	4.9
Average Family Size-Children	4.2	NA	4.8	4.1	3.6
Average No. Children-Children	2.6	NA	2.9	2.8	2.0
Average Household Size-Adults	3.9	3.2	3.7	3.3	4.0
Average Family Size-Adults	2.9	2.4	3.2	2.9	3.2
Average No. Children-Adults	1.4	1.2	1.6	1.0	2.0

Family Characteristics of the Medically Indigent

- Children with single parents
- Single adults
- Large households

ECONOMIC CHARACTERISTICS OF THE MEDICALLY INDIGENT

CHARACTERISTIC	UNINSURED	MEDICARE ONLY	PRIVATE ONLY	COMBINED COVERAGE	MEDICAID ENROLLED
ANNUAL FAMILY INCOME	$ 3,504	$ 3,224	$ 4,196	$ 2,446	$ 3,379
Children	4,016	NA	5,260	3,191	3,495
Adults	2,915	3,661	3,482	2,053	3,239
Elderly	869*	3,069	2,590*	2,399*	2,916*
FAMILIES WITH EARNINGS	64 %	17 %	85 %	52 %	40 %
EARNINGS AS PERCENT OF FAMILY INCOME					
Among All Families	65	2	80	30	21
Among Families with Earnings	82	14	83	60	45
GOVERNMENT PAYMENTS AS PERCENT OF FAMILY INCOME	28	97	12	40	78
Children	26	NA	8	30	76
Adults 18-64	30	93	15	37	79
Elderly	30	98	42	85	100
FAMILY RECEIVES FOOD STAMPS	35	24	14	31	65
Children	46	NA	35	52	86
Adults 18-64	26	28	9	27	54
Elderly	7	22	2	13	17
CHILDREN RECEIVE FREE/ LOW COST LUNCHES	62	NA	58	78	83
FAMILY LIVES IN PUBLIC HOUSING	4	4	2	1	10
Children	5	NA	2	0	14
Adults 18-64	4	7	1	2	8
Elderly	0	3	2	3	5
GOVERNMENT SUBSIDIZED RENT	2	1	0	1	8
Children	2	NA	0	2	10
Adults 18-64	1	1	0	1	7
Elderly	0	1	0	0	1
FAMILY RECEIVES AFDC OR SSI	15	36	6	15	82
Children	9	NA	0	12	89
Adults 18-64	19	40	8	17	83
Elderly	43	35	7	10	51
FAMILY RECEIVES SOCIAL SECURITY	22	89	18	36	25
Children	21	NA	2	22	14
Adults 18-64	23	75	15	28	21
Elderly	29	95	93	87	81
ADULTS 18-64, SELECTED SOURCES OF FAMILY SUPPORT					
Unemployment Compensation	18	6	19	14	4
Workmen's Compensation	5	0	3	1	1
Veteran's Payments	5	21	5	2	14
FAMILY OWNS HOME	40	36	26	42	16
LIVES IN MOBILE HOME	12	8	10	2	10

SOURCE: Bureau of the Census, CURRENT POPULATION SURVEY, Annual Demographic File, 1980, 1982, 1983, 1984, 1985 (North Carolina data only).

Economic Characteristics of Medically Indigent

- Lower family income
- Less earned income
- More government support
  - Food Stamps
  - Free school lunches
  - Public housing/rent subsidies
- More amenities
  - Own home
  - Phone in home

EMPLOYMENT STATUS OF UNINSURED POOR ADULTS
AGE 18 TO 64

EMPLOYMENT STATUS	COMBINED ESTIMATE	NORTH CAROLINA CITIZENS SURVEY	CURRENT POPULATION SURVEY
Full time	29.9	32.1	27.7
Part time	22.0	13.5	30.4
Unemployed	26.5	16.6	36.4
Not in labor force	21.6	37.8	5.4

NOTE: Combined figure is a simple average of NCCS and CPS data.

EDUCATION & EMPLOYMENT CHARACTERISTICS OF THE MEDICALLY INDIGENT
ADULTS AGE 18-64

CHARACTERISTIC	UNINSURED	MEDICARE ONLY	PRIVATE ONLY	COMBINED COVERAGE	MEDICAID ENROLLED
EDUCATION (ADULTS 18-64)					
0 to 8 years	13 %	59 %	9 %	17 %	16 %
9 to 11 years	25	15	24	21	26
12 years	12	10	12	9	15
13 to 15 years	43	15	42	47	40
16 or more years	7	0	13	6	2
PERCENT OF EMPLOYED PERSONS WHO HAVE TWO JOBS	12	0	13	6	7
PERCENT OF FAMILIES WHERE ALL HOUSEHOLD ADULTS WERE NOT WORKING AT LEAST PART OF YEAR	48	69	18	36	63
PERCENT NOT WORKING	43	94	30	46	60
PERCENT OF EMPLOYED PERSONS WHO ARE SELF-EMPLOYED	14	25	13	12	5
LABOR FORCE STATUS OF SPOUSE					
Spouse present, in labor force	12	3	24	12	4
Spouse present, not in labor f.	31	33	31	26	8
Male householder, no spouse	17	28	13	11	6
Female householder, no spouse	41	36	32	50	82

SOURCES: Bureau of the Census, CURRENT POPULATION SURVEY, Annual Demographic File, 1980, 1982, 1983, 1984, 1985 (North Carolina data only).
Office of State Budget and Management, NORTH CAROLINA CITIZENS SURVEY, 1979, 1981, 1982, 1983, 1984.

ESTIMATED DISTRIBUTION OF EMPLOYED UNINSURED
NORTH CAROLINA, 1985

SIZE OF EMPLOYER	PERCENT OF TOTAL EMPLOYEES	ASSUMED PERCENT NOT COVERED	ESTIMATED SHARE OF EMPLOYEES WITHOUT GROUP HEALTH COVERAGE
19 or less	20.0 %	57.5 %	40 %
20 to 250	33.2	31.9	37
251 to 1000	27.9	13.9	14
Over 1000	18.8	13.5	9
TOTAL	100.0		100

NOTE: Distribution of employees by size of employer obtained from COUNTY BUSINESS PATTERNS 1983, NORTH CAROLINA. Figures on percent not covered are based on national data reported in Taylor and Lawson (1981). No North Carolina data are available on coverage rates by size of employer. Estimated share of employees without group health coverage is computed based on the assumed percent not covered.

SOURCES: Bureau of the Census, COUNTY BUSINESS PATTERNS 1983, NORTH CAROLINA. Washington, D.C.: Bureau of the Census, CBP-83-35, September, 1985.

Amy Taylor and Walter Lawson, Jr. EMPLOYER AND EMPLOYEE EXPENDITURES FOR PRIVATE HEALTH INSURANCE. Hyattsville, MD: National Center for Health Services Research, National Health Care Expenditures Study, Data Preview 7, June 1981.

Deborah Chollet, EMPLOYER-PROVIDED HEALTH BENEFITS. Washington, D.C.: Employee Benefits Research Institute, 1984.

Health Insurance Coverage by Size of Employer

	Size of Employer			
	25 or Less	26 to 250	251 to 1000	Over 1000
Percent Offering Health Insurance	55.4	92.3	97.8	99.3
Percent of All Employees Eligible	97.1	92.4	89.3	90.1
Percent of Eligible Employees Participating	79.0	79.8	97.7	96.7
Net Percent of Employees Covered	42.5	68.1	86.1	86.5

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NOTE: Figures on percent of employers offering coverage and percent of employees eligible obtained from Taylor and Lawson (1981). Figures on percent of employees participating obtained from Chollet (1984), which is based on combining data from the Bureau of Labor Statistics survey of medium and large employers with a Battelle survey of small employers.

Barriers to Access

for the Medically Indigent

HEALTH STATUS OF ADULTS IN NORTH CAROLINA

CHARACTERISTIC	UNINSURED	MEDICARE ONLY	PRIVATE ONLY	COMBINED COVERAGE	MEDICAID ENROLLED
SELF REPORTED HEALTH STATUS					
Excellent	23 %	6 %	35 %	25 %	14 %
Good	31	17	32	32	23
Fair	20	19	16	18	23
Poor	12	23	4	10	17
CHRONIC HEALTH CONDITIONS					
Arthritis	21	56	17	33	38
High blood pressure	20	47	17	21	38
Heart disease	7	26	4	7	16
Kidney disease	6	17	5	5	10
Lung disease	4	6	2	3	6
Diabetes	4	13	3	6	10
Cancer	3	8	2	3	4
Stroke	3	8	1	1	6
Glaucoma	1	6	1	2	3
At least one condition	38	79	35	35	62
DISABILITY/ILL HEALTH PREVENTS WORKING	6	18	1	6	15

NOTE: All figures are for all adults regardless of poverty status. Percentages shown are based on weighted observations.

SOURCE: Office of State Budget and Management, NORTH CAROLINA CITIZENS SURVEY, 1979, 1981, 1982, 1983 and 1984.

INSURANCE COVERAGE OF PERSONS IN NORTH CAROLINA BY DISABILITY STATUS, 1976

AGE AND DISABILITY STATUS	SAMPLE SIZE	UNINSURED	INSURED		
			Private Only	Other Private	Public Only
AGE 3 TO 17					
No activity limitation	1151	16.1	75.0	1.8	6.8
With activity limitation	66	17.1	71.4	0.0	11.5
AGE 18 TO 64					
No work disability	2161	11.6	82.6	1.5	3.7
With work disability	403	21.3	53.3	8.9	14.8
Able to work regularly	160	18.3	73.5	3.2	4.3
Not able to work regularly	53	21.7	63.1	6.7	5.0
Prevented from working	177	24.7	30.4	14.8	27.7
AGE 65 AND OVER					
No activity limitation	287	5.2	5.9	45.8	42.7
With activity limitation	219	3.9	3.4	40.4	51.2
ALL PERSONS	4511	13.5	70.0	7.5	9.7

Uninsured Poor Are Sicker

- Worse Self-Reported Health
- More Chronic Conditions
- More Disability
- More Mental Illness

MAJOR ACCESS BARRIERS FOR THE MEDICALLY INDIGENT

CHARACTERISTIC	UNINSURED	MEDICARE ONLY	PRIVATE ONLY	COMBINED COVERAGE	MEDICAID ENROLLED
PROBLEMS IN GETTING MEDICAL CARE					
Children	5 %	1 %	1 %	4 %	1 %
Adults	13	11	2	6	8
TYPE OF ACCESS PROBLEMS FOR ADULTS (Percent of those reporting problem)					
Cost	66	54	50	16	58
Refused care by provider	28	0	12	0	14
Transportation	4	18	4	16	0
Geography	4	0	12	0	5
AVERAGE DRIVING TIME TO MAIN SOURCE OF CARE (minutes)					
Children	23	23	17	20	23
Adults	24	26	17	19	24

NOTE: All figures are for all persons regardless of poverty status.

SOURCE: Office of State Budget and Management, NORTH CAROLINA CITIZENS SURVEY, 1979, 1981, 1982, 1983 and 1984.

Major Access Barriers for the Medically Indigent

- Higher self-reported access barriers
- Cost a key barrier to access
- Some geographic barriers
- Provider barriers appear minor

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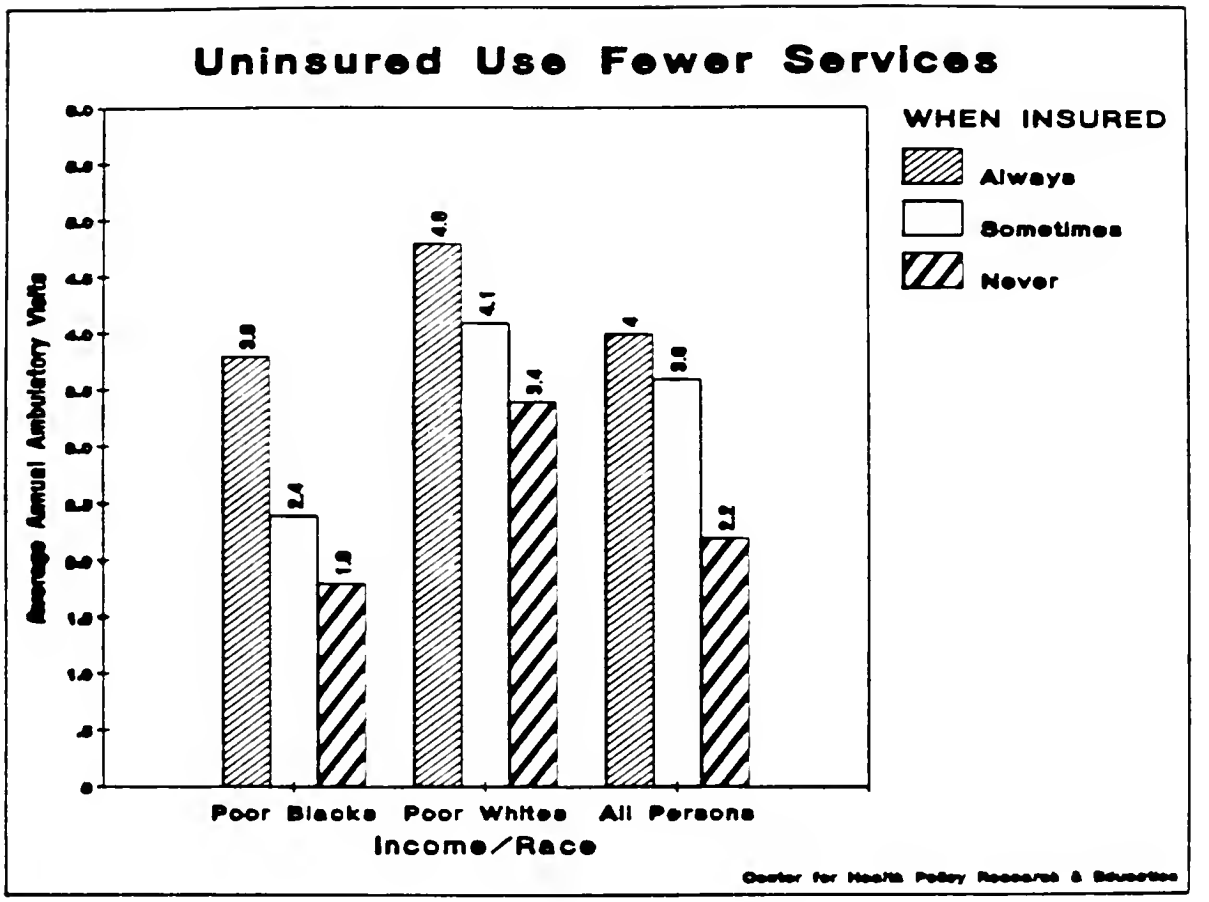
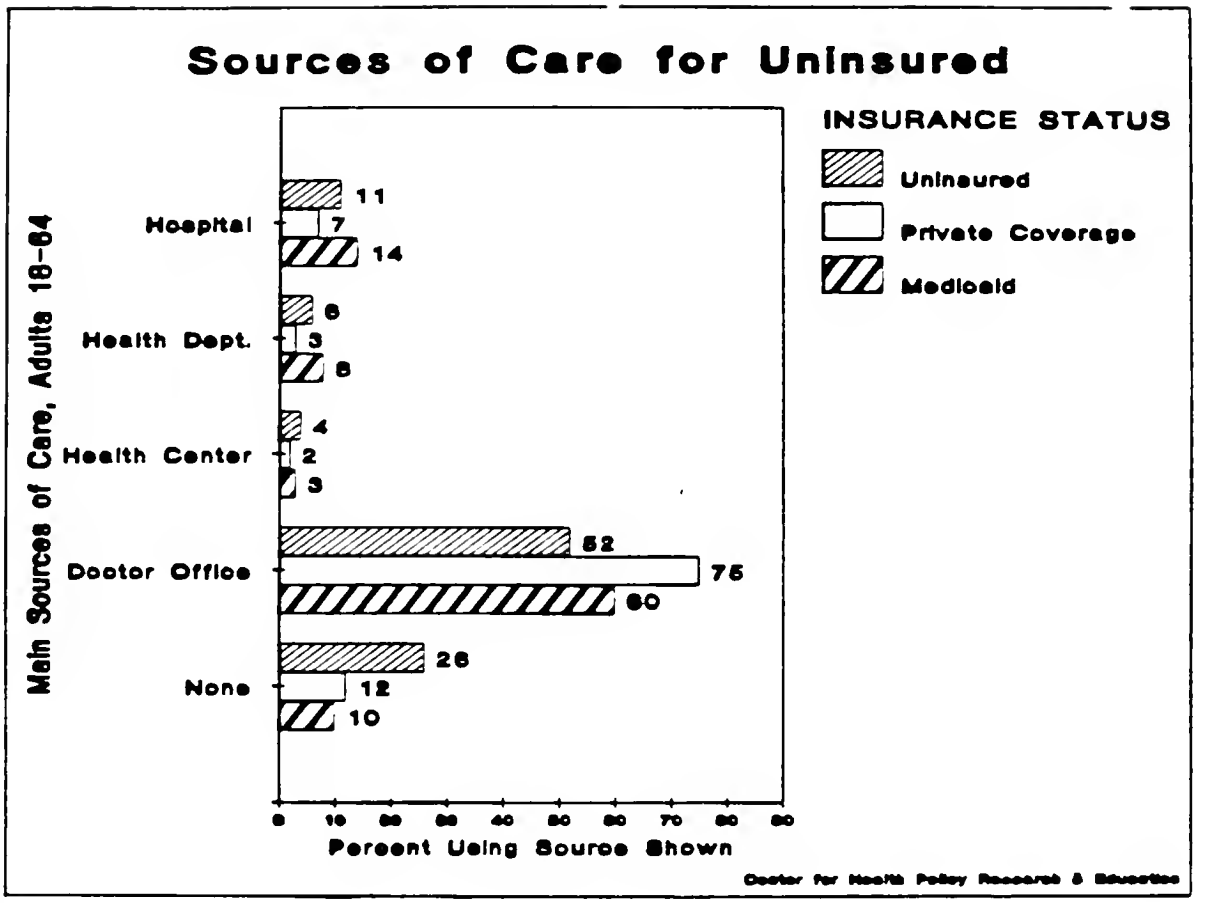

Uninsured Use Fewer Services
WHEN INSURED
Always
Sometimes
Never
Average Annual Ambulatory Visits
2.8
2.4
1.8
4.8
4.1
3.4
4
3.8
2.2
Poor Blacks
Poor Whites
All Persons
Income/Race

MAJOR SOURCES OF MEDICAL CARE IN NORTH CAROLINA

CHARACTERISTIC	UNINSURED	MEDICARE ONLY	PRIVATE ONLY	COMBINED COVERAGE	MEDICAID ENROLLED
MAIN SOURCE OF MEDICAL CARE FOR CHILDREN					
Hospital emergency room	2 %	0	1 %	5 %	2 %
VA hospital	2	0	0	0	0
Hospital outpatient clinic	6	0	1	2	8
Hospital Subtotal:	11	0	2	7	10
Public health department	9	7	3	2	7
Community health center	3	0	1	1	3
Doctor's office	35	24	46	22	31
No main source	42	69	47	59	48
MAIN SOURCE OF MEDICAL CARE FOR ADULTS					
Hospital emergency room	5	2	2	1	6
VA hospital	2	5	1	6	2
Hospital outpatient clinic	2	5	3	9	8
Hospital Subtotal:	10	11	5	21	10
Public health department	6	2	3	3	8
Community health center	4	2	2	*	2
Doctor's office	52	70	75	75	66
No main source	29	12	14	8	10
REASON FOR NO MAIN SOURCE OF MEDICAL CARE (Adults)					
Not needed	69	67	76	55	52
Can't afford	16	0	1	7	10
Uses several doctors	9	8	10	21	16
Could not find doctor	2	0	2	0	0
Previous doctor gone	0	0	1	16	0
Recently moved	2	0	8	0	6
USED EMERGENCY ROOM AT LEAST ONCE DURING YEAR (Adults)	23	28	19	17	25
REASONS FOR USING EMERGENCY ROOM (Adults)					
Had medical emergency	77	54	71	36	52
Needed doctor after hours	18	15	22	64	36
No usual source of care/ didn't know where else to go	4	19	2	0	8
Other reason	1	0	3	0	3

NOTE: All figures are for all persons regardless of poverty status. All data are weighted.

SOURCE: Office of State Budget and Management, NORTH CAROLINA CITIZENS SURVEY, 1979, 1981, 1982, 1983 and 1984.


Sources of Care for Uninsured
INSURANCE STATUS
Uninsured
Private Coverage
Medicaid
Main Sources of Care, Adults 18-64
Hospital
11
7
14
Health Dept.
6
3
8
Health Center
4
2
3
Doctor Office
52
75
60
None
26
12
10
0
10
20
30
40
50
60
70
80
90
Percent Using Source Shown

LEADING CAUSES OF HOSPITALIZATION
FOR SELF-PAY PATIENTS
NORTH CAROLINA, 1980

DIAGNOSTIC CATEGORY	SELF PAY	BLUE CROSS	MEDICAID
	Percent of All Admissions		
Childbirth and puerperium	28.6 %	14.3 %	18.1 %
Accidents, poisonings and violence	14.6	6.6	6.7
Diseases of digestive system	9.3	13.1	10.6
Mental disorders	8.4	3.3	4.7
Diseases of circulatory system	6.2	8.2	7.7
All other diseases	32.9	54.5	52.2
TOTAL	100.0 %	100.0 %	100.0 %
Sample Size	n=53,939	n=161,567	n=47,027

SOURCE: 1980 data for 97 North Carolina short-stay general hospitals, made available through the State Center for Health Statistics.

MAIN SOURCE OF PAYMENT FOR
SELECTED MEDICAL PROCEDURES

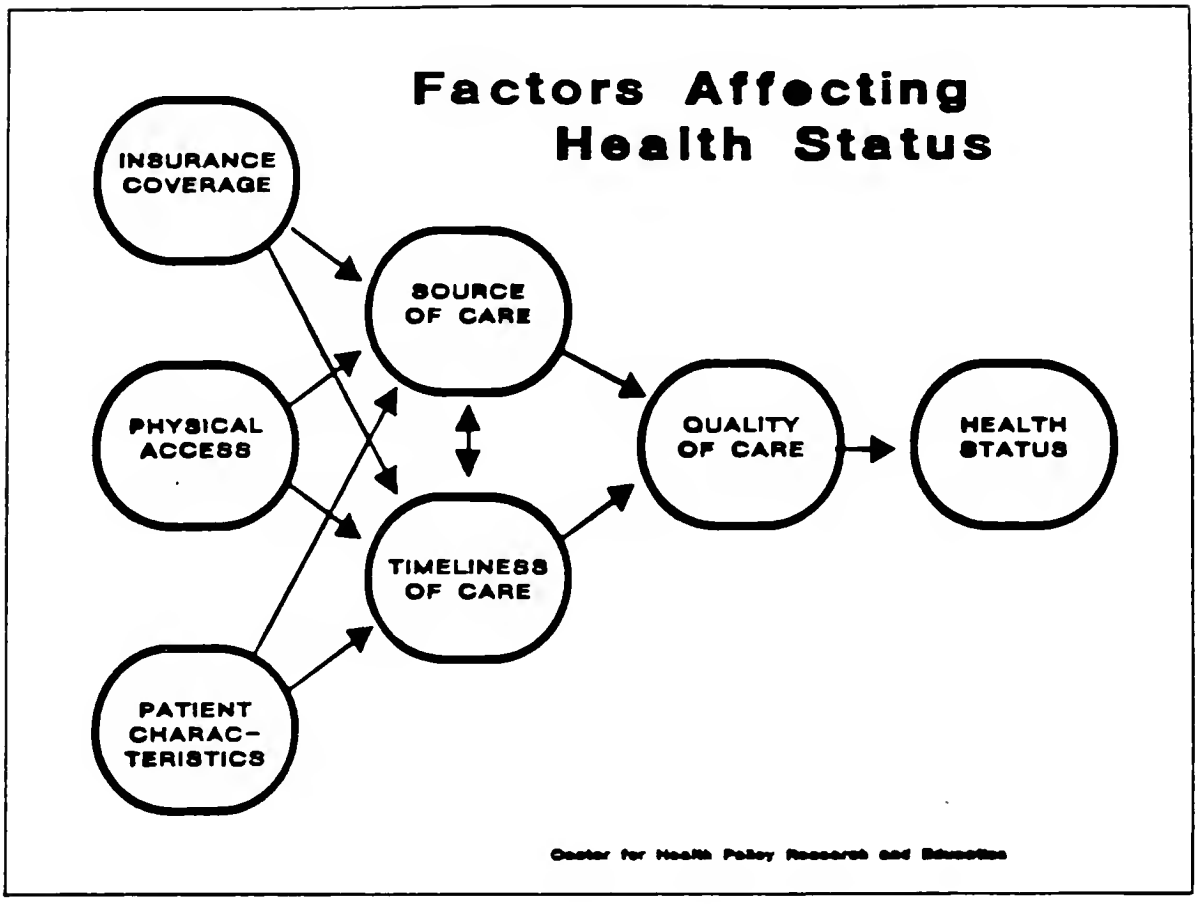
	Medicare	Medicaid	Blue Cross	Private insurance	Self-pay
Cardiac bypass	1.8%	6.1%	34.7%	57.3%	0.0%
Simple mastectomy	41.4	3.6	23.2	26.6	3.3
Cataract surgery	72.6	4.0	9.1	10.3	1.4
Lens implant	80.4	1.0	7.5	9.3	1.0
Hip replacement	74.2	3.6	8.8	11.0	1.1
Cesarean section	0.3	13.6	30.4	42.2	9.0
Other deliveries	0.2	12.9	28.1	41.9	10.9
Coronary artery surgery	36.2	2.2	21.4	36.5	1.6
Peptic ulcer treatment	44.5	5.5	19.1	23.5	4.2
Prostatectomy	75.0	1.4	9.6	12.1	0.9
Cholecystectomy	29.5	7.1	26.0	31.6	3.4

Source. Unpublished data from National Hospital Discharge Survey, 1981.

SOURCE: James M. Perrin, "High Technology and Uncompensated Hospital Care" in Frank Sloan, James Blumstein and James Perrin, UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES. Baltimore: Johns Hopkins University Press, 1986.

Hospital Use by Medically Indigent

- Elective care deferred
- Most common admissions:
  - childbirth
  - accidents
  - mental disorders
- Less use of high technology


Factors Affecting
Health Status
INSURANCE COVERAGE
PHYSICAL ACCESS
PATIENT CHARAC-TERISTICS
SOURCE OF CARE
TIMELINESS OF CARE
QUALITY OF CARE
HEALTH STATUS

Summary: Medically Indigent in North Carolina

- Large population at risk
- Heterogeneous mixture
- Multiple causes
- Worse health
- Barriers to access
- Fewer services
- Patchwork could be improved

Center for Health Policy Research & Education

HEALTH CARE FOR THE MEDICALLY INDIGENT

Payment and Responsibility for

Indigent Health Care

Presentation to:

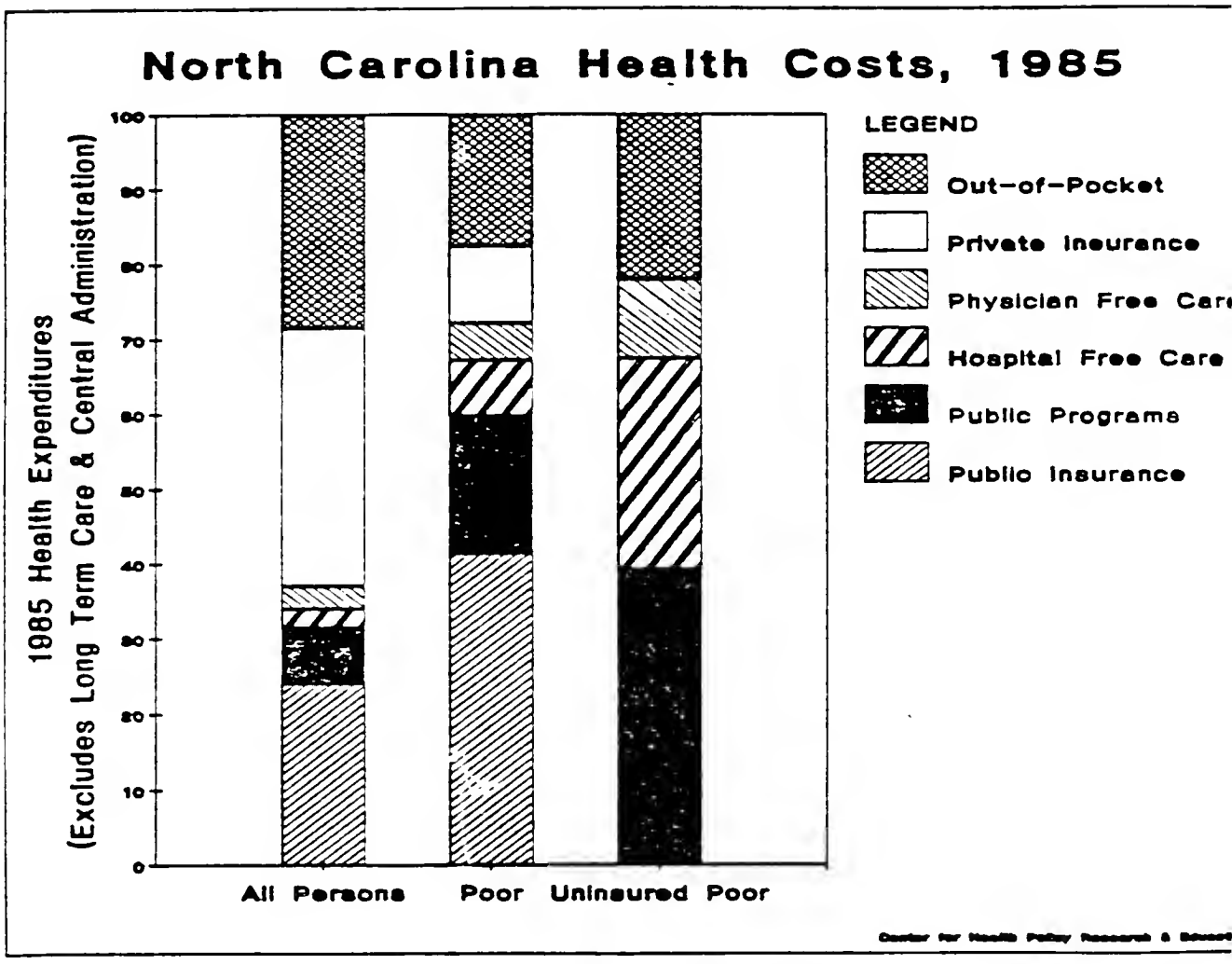
INDIGENT HEALTH CARE STUDY COMMISSION

By

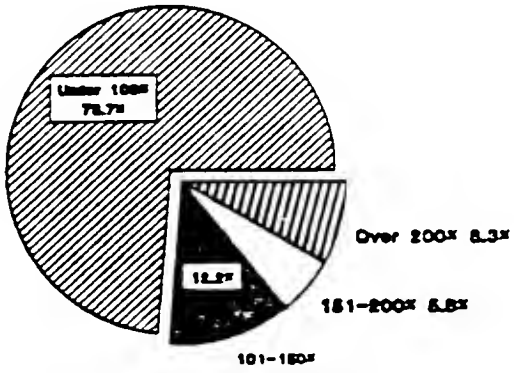
Christopher J. Conover
Research Associate
Center for Health Policy Research & Education
Duke University

Payment and Responsibility for Indigent Health Care

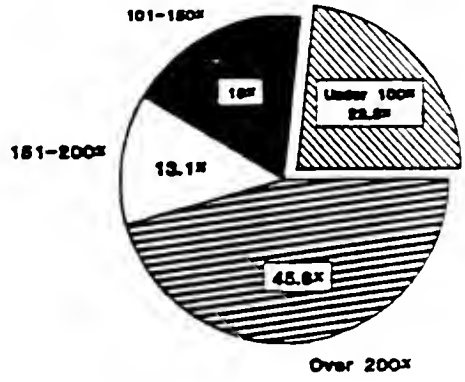
- How much do we spend?
- Who gets benefits?
- Who pays the cost?
- Financing trends
- Current inequities
- Public responsibility


North Carolina Health Costs, 1985
1985 Health Expenditures
(Excludes Long Term Care & Central Administration)
100
90
80
70
60
50
40
30
20
10
0
All Persons
Poor
Uninsured Poor
LEGEND
Out-of-Pocket
Private Insurance
Physician Free Care
Hospital Free Care
Public Programs
Public Insurance

Public Insurance
North Carolina, 1985



$312 m. Medicaid (Acute Costs)



$1,262 m. Medicare

Public Medical Programs Serving Uninsured Poor

ENTITLEMENTS
VA Health
Migrant Health
Refugee Health
Indian Health

HEALTH CENTERS
Rural Health Ctrs
Federal CHCs
NHSC

MATERNAL/CHILD
Maternal Health
Family Planning
High Risk Maternity
Perinatal
Delivery Fund
Sterilizations
Abortion Fund
Child Health
Immunization
School Health
Dental Health

ADULT HEALTH
Primary Care
Adult Health
Cancer Control
Kidney Disease
TB Control
VD Control

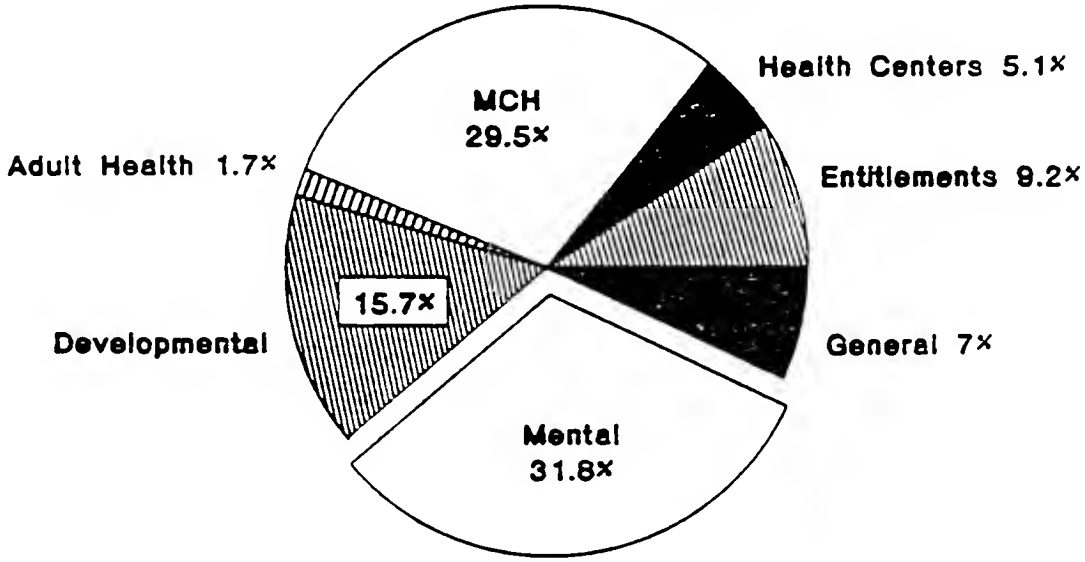
GENERAL HEALTH
County Health Aid
Home Health
Eye Care
Emergency Medical

DEVELOPMENTAL
Voc. Rehab.
Genetic Health
DECs
Crippled Children
Lenox Baker Hospital

MENTAL HEALTH
CMHCs
ARCs
State Hospitals

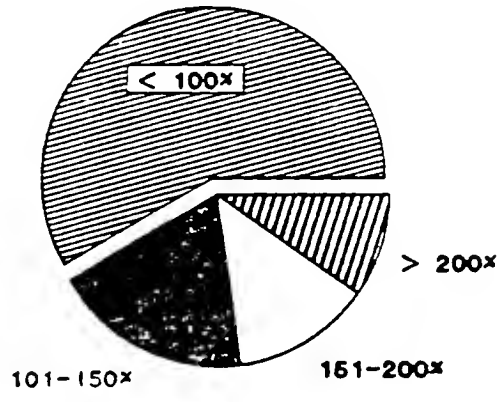
Center for Health Policy Research & Education

FY85 Outlays on Persons Below Poverty
Public Medical Programs

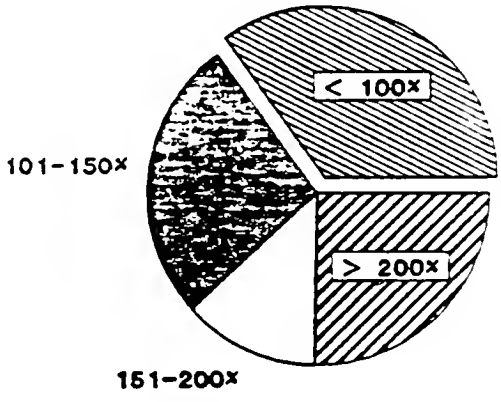


$101 Million for Uninsured Poor

Public Medical Program Costs, 1985

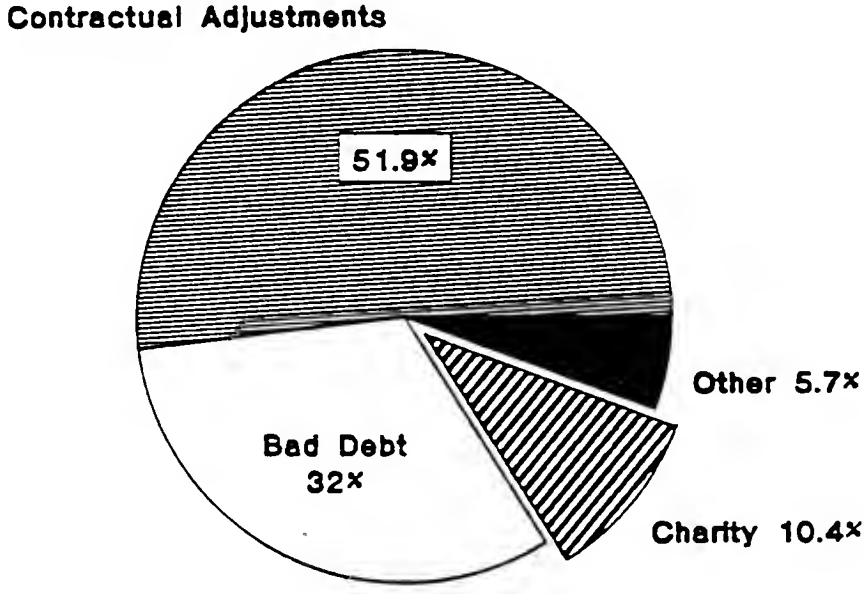


$174 m. for Uninsured

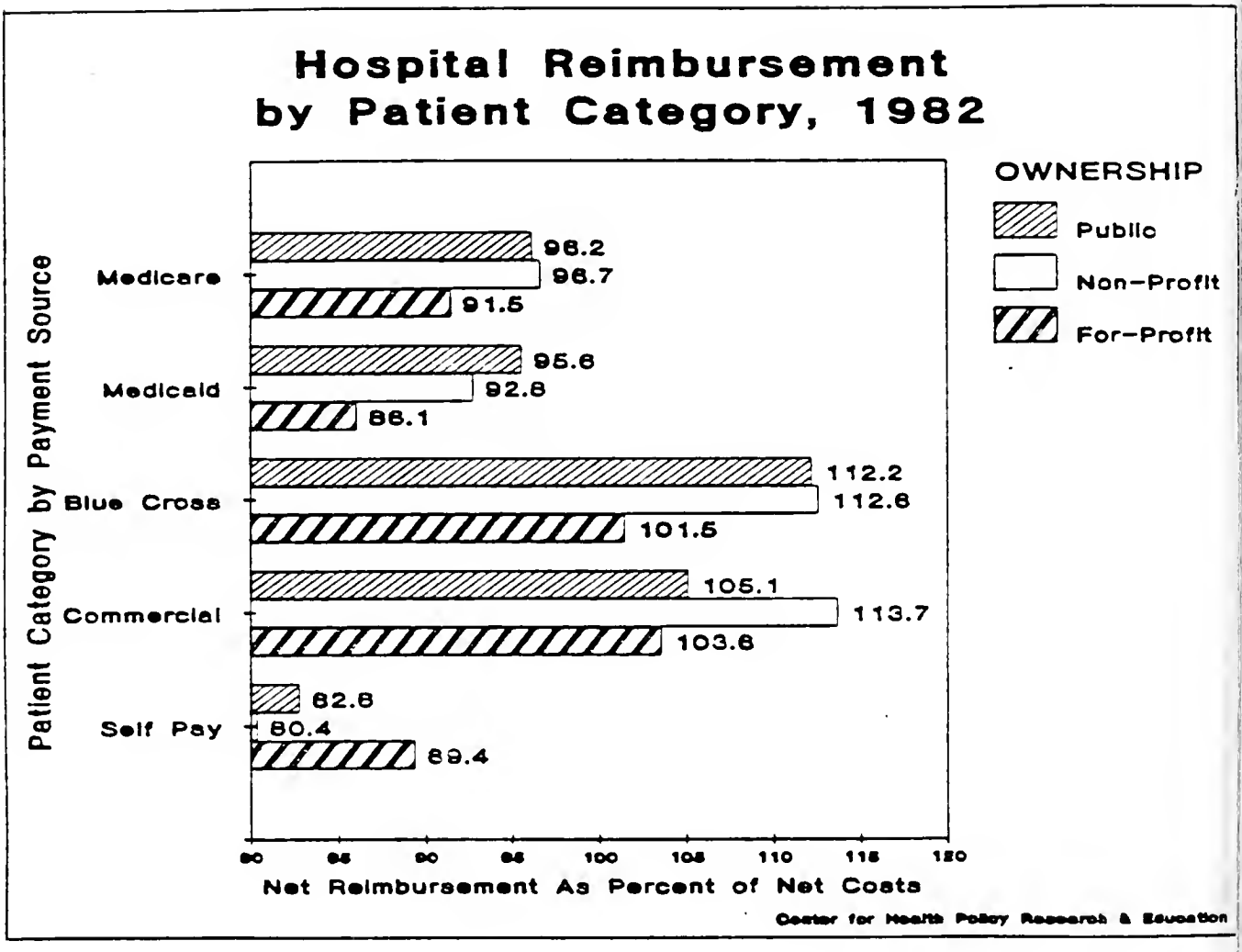


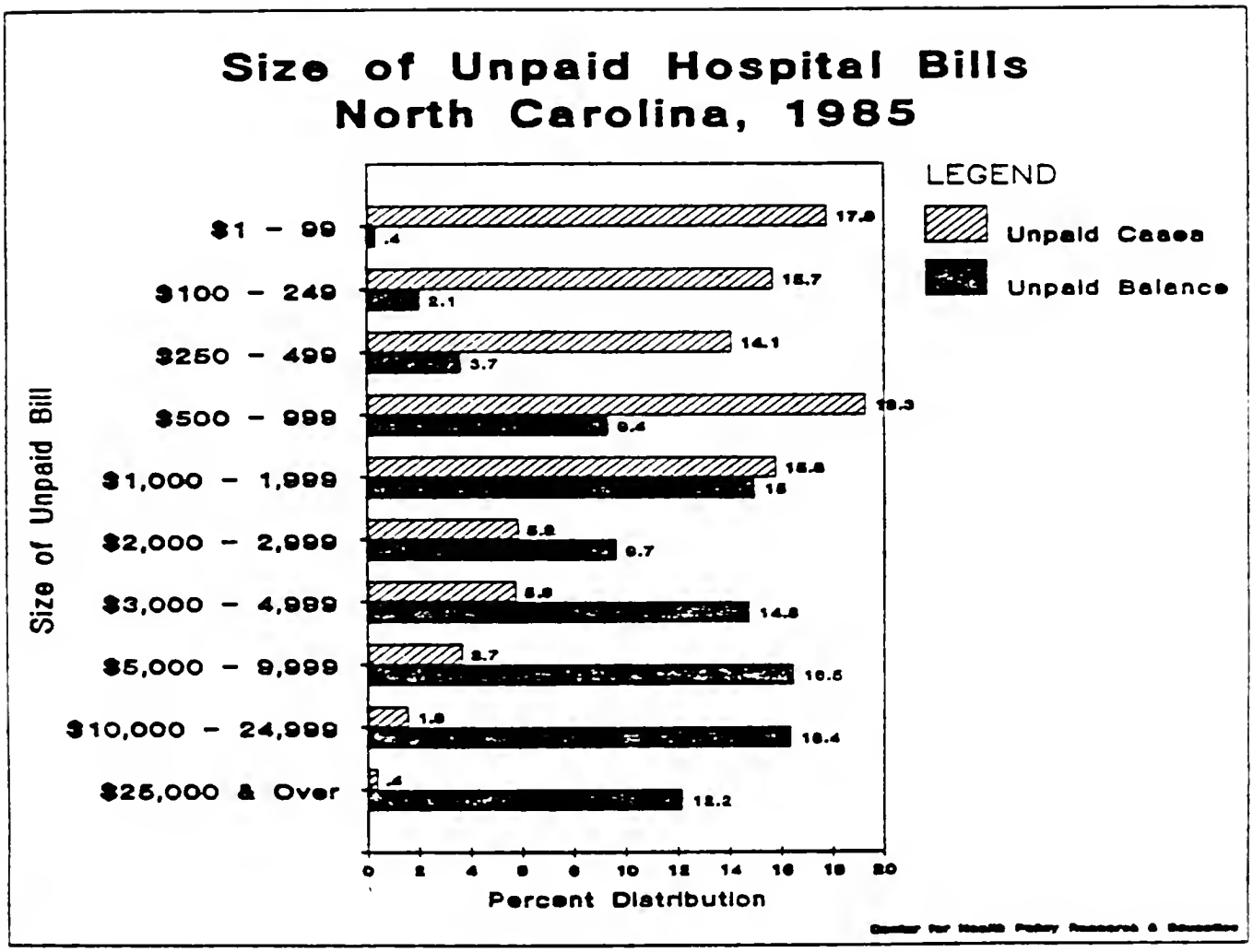
$285 m. for Insured

Hospital Gross Revenue Deductions, 1982

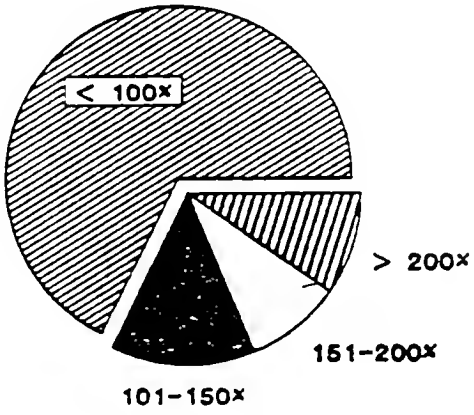


FY84 Deductions: $412.0 Million

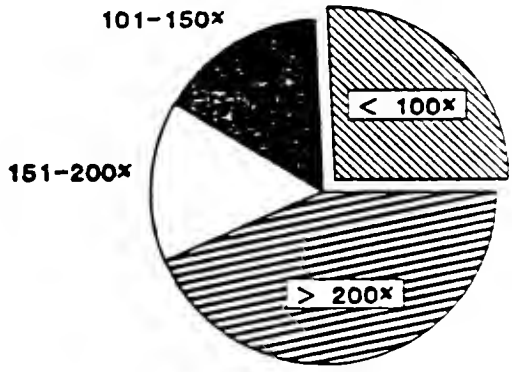

Hospital Reimbursement
by Patient Category, 1982
OWNERSHIP
Public
Non-Profit
For-Profit
Patient Category by Payment Source
Medicare
96.2
96.7
91.5
Medicaid
95.6
92.8
86.1
Blue Cross
112.2
112.6
101.5
Commercial
105.1
113.7
103.6
Self Pay
82.8
80.4
89.4
80
85
90
95
100
105
110
115
120
Net Reimbursement As Percent of Net Costs
Center for Health Policy Research & Education


Size of Unpaid Hospital Bills
North Carolina, 1985
LEGEND
Unpaid Cases
Unpaid Balance
Size of Unpaid Bill
$1 - 99
$100 - 249
$250 - 499
$500 - 999
$1,000 - 1,999
$2,000 - 2,999
$3,000 - 4,999
$5,000 - 9,999
$10,000 - 24,999
$25,000 & Over
17.8
.4
15.7
2.1
14.1
3.7
9.4
15.8
15
8.7
14.8
8.7
16.5
1.8
16.4
.4
12.2
0
2
4
6
8
10
12
14
16
18
20
Percent Distribution

Hospital Free Care, 1985

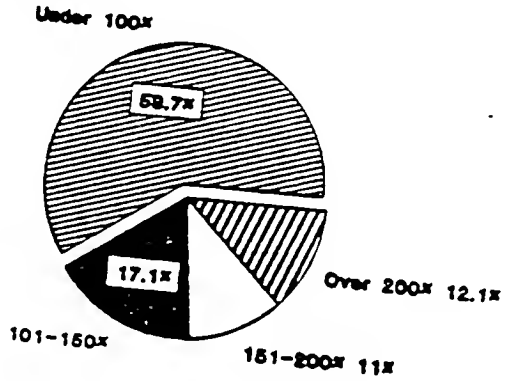


$124 m. for Uninsured

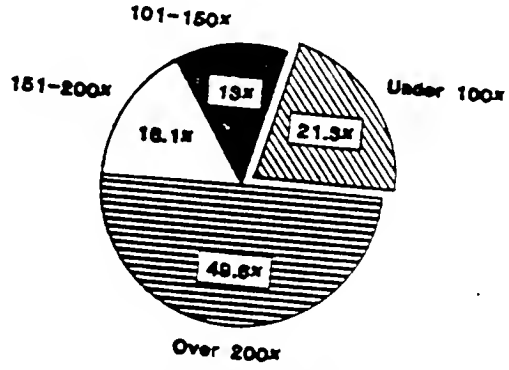


$48 m. for Insured

Physician Free Care
North Carolina, 1985

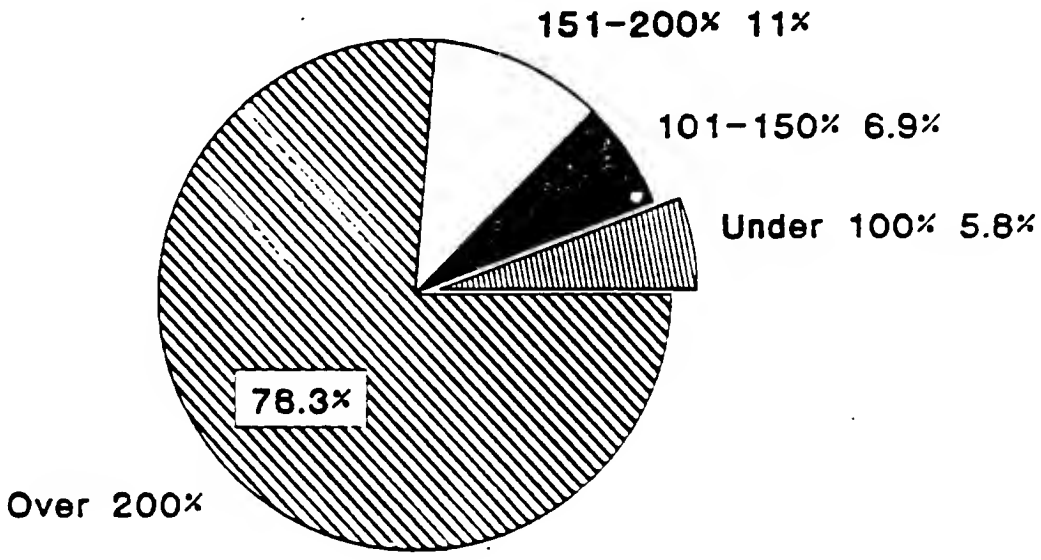


$52 m. for Uninsured



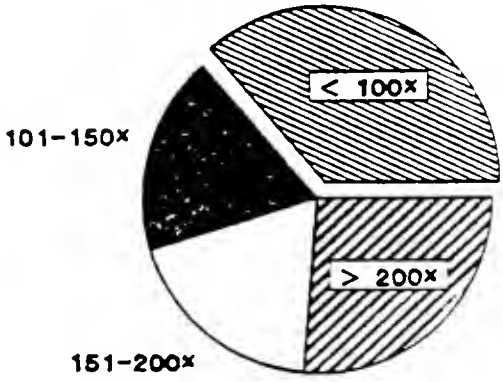
$148 m. for Insured

Private Insurance Benefits, 1985

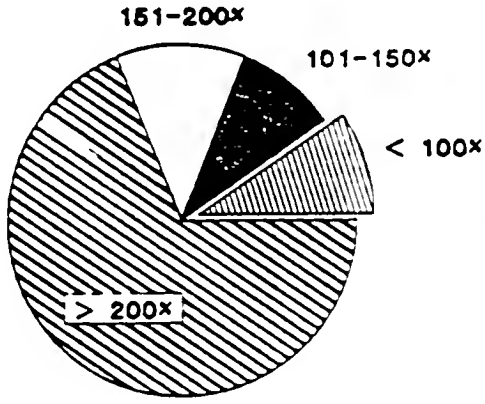


$2,266 m. Benefits Paid

Out-of-Pocket Health Expenses, 1985

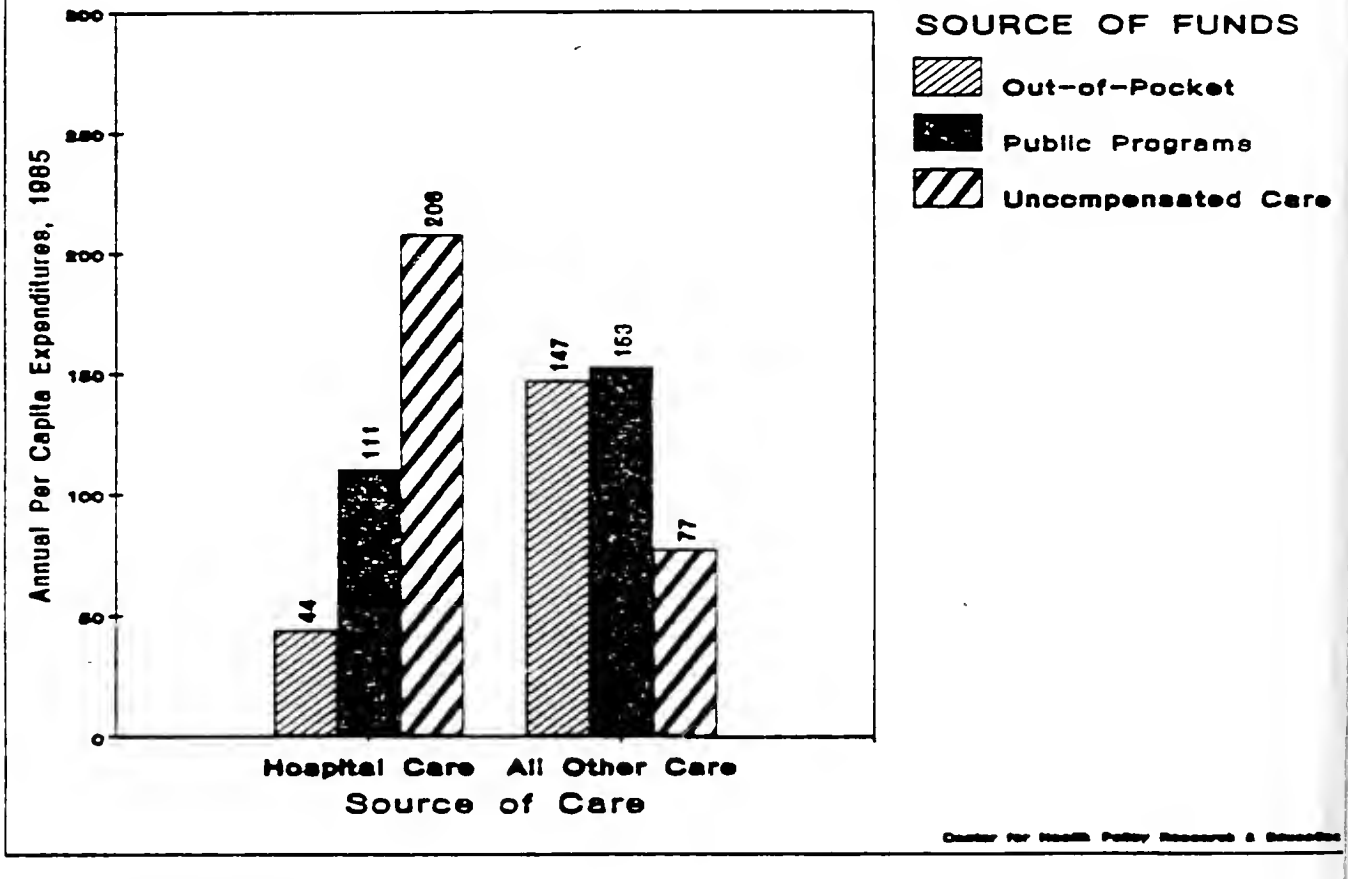


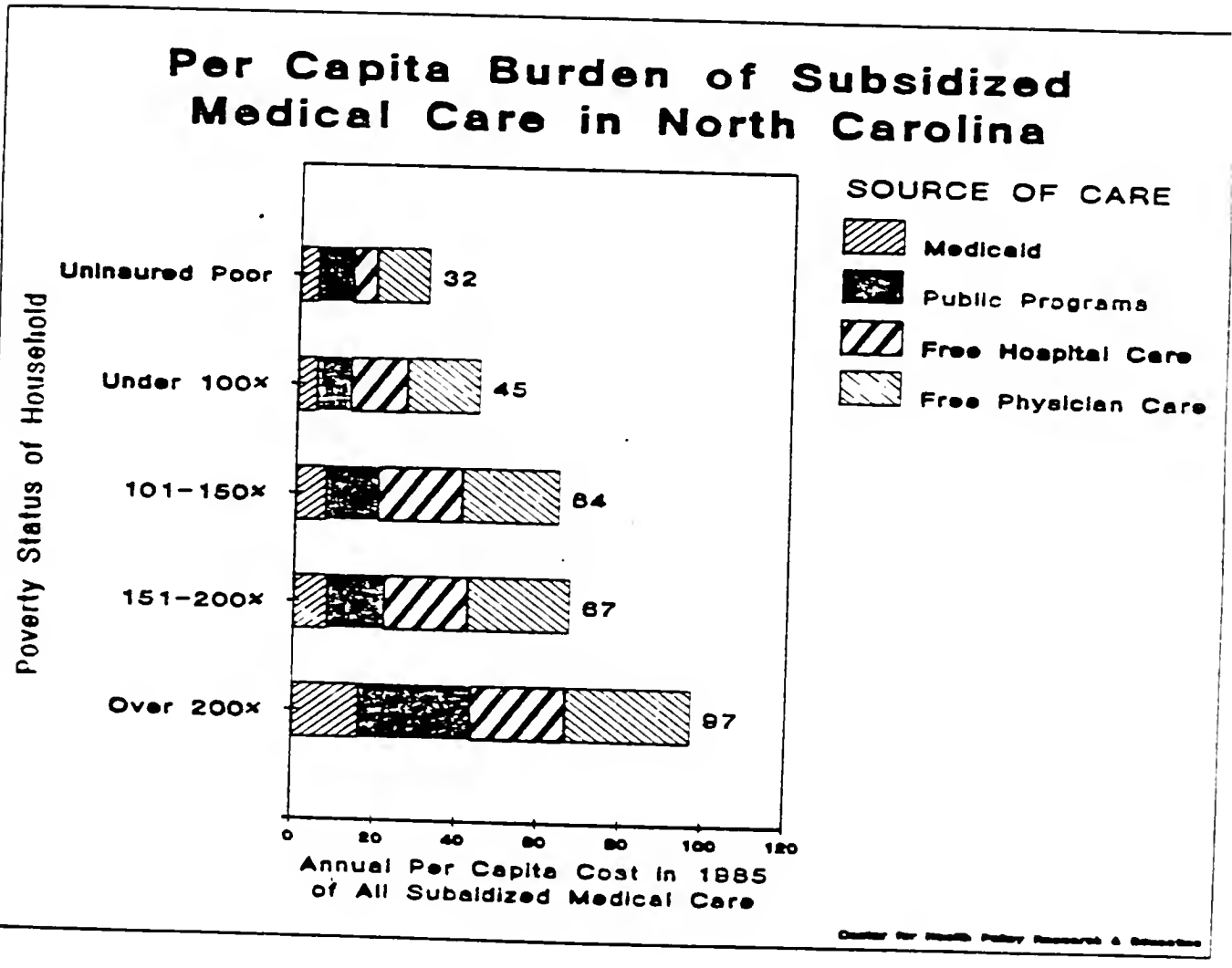
$214 m. for Uninsured



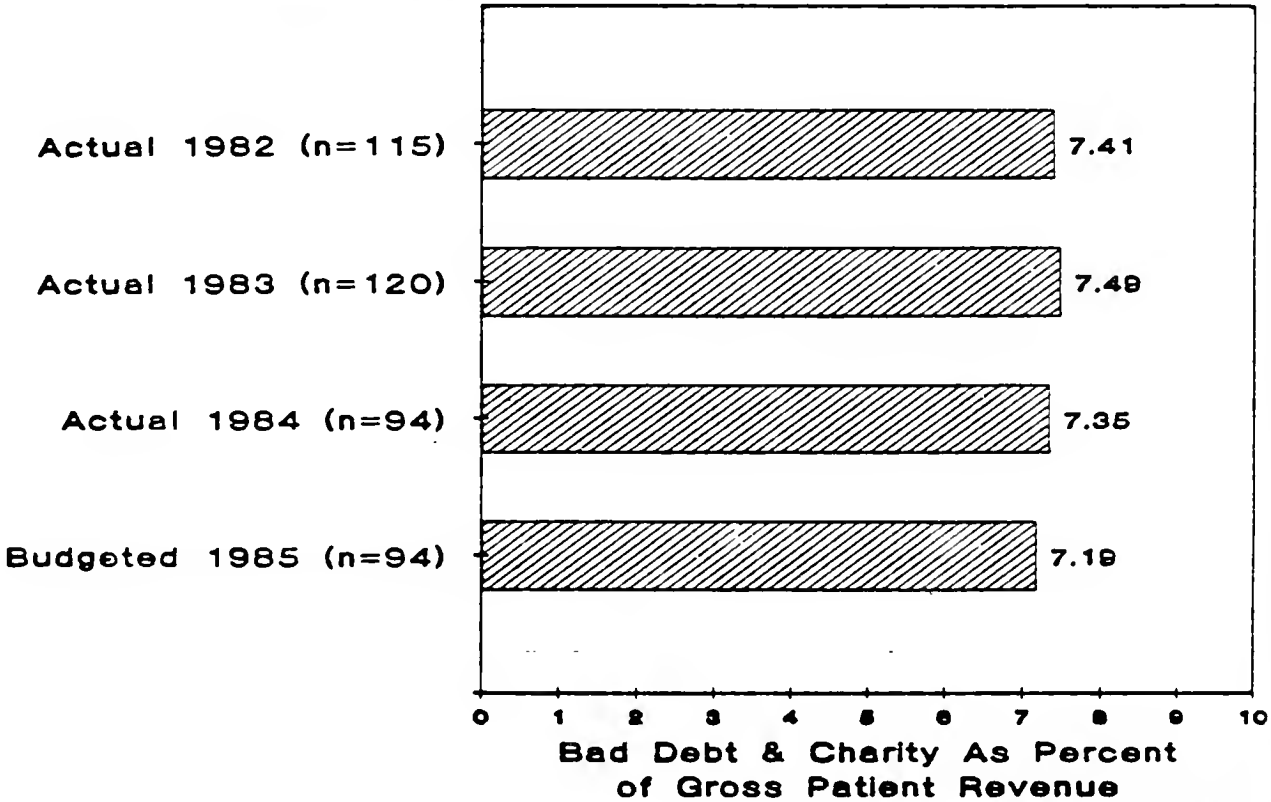
$1,665 m. for Insured

Health Expenditures Per Capita for Uninsured Poor




Per Capita Burden of Subsidized Medical Care in North Carolina
Poverty Status of Household
Uninsured Poor
Under 100%
101-150%
151-200%
Over 200%
32
45
84
87
97
0
20
40
60
80
100
120
Annual Per Capita Cost in 1985 of All Subsidized Medical Care
SOURCE OF CARE
Medicaid
Public Programs
Free Hospital Care
Free Physician Care

Trends in Bad Debts and Charity Care North Carolina Hospitals, 1982 – 1985



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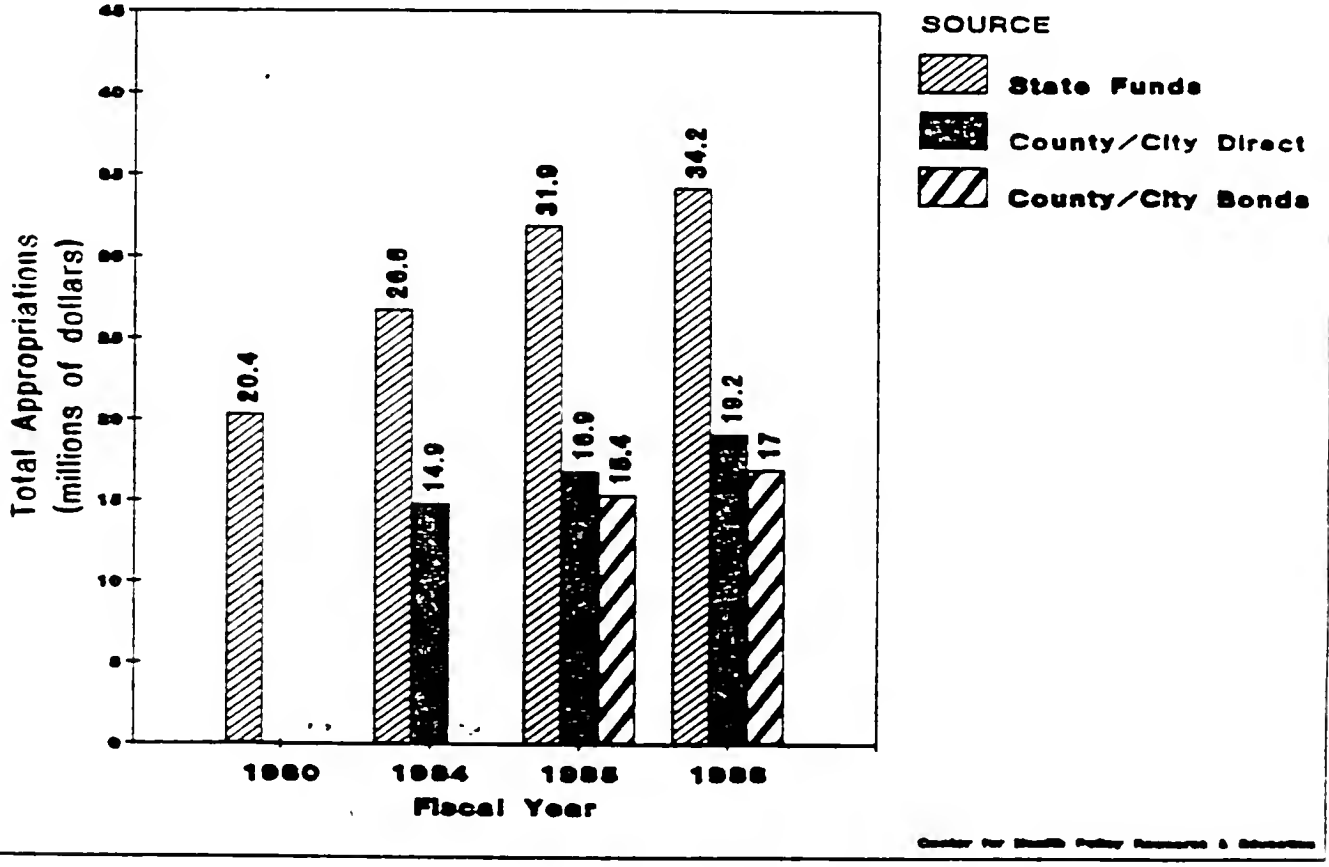
Trends in Government Hospital Payments North Carolina, 1980 – 1986



Inequities in Provision of Indigent Health Care

- Disparate eligibility criteria
- Unequal service availability
- Unequal financial burden
  - Across counties
  - Across hospitals
  - Across physicians

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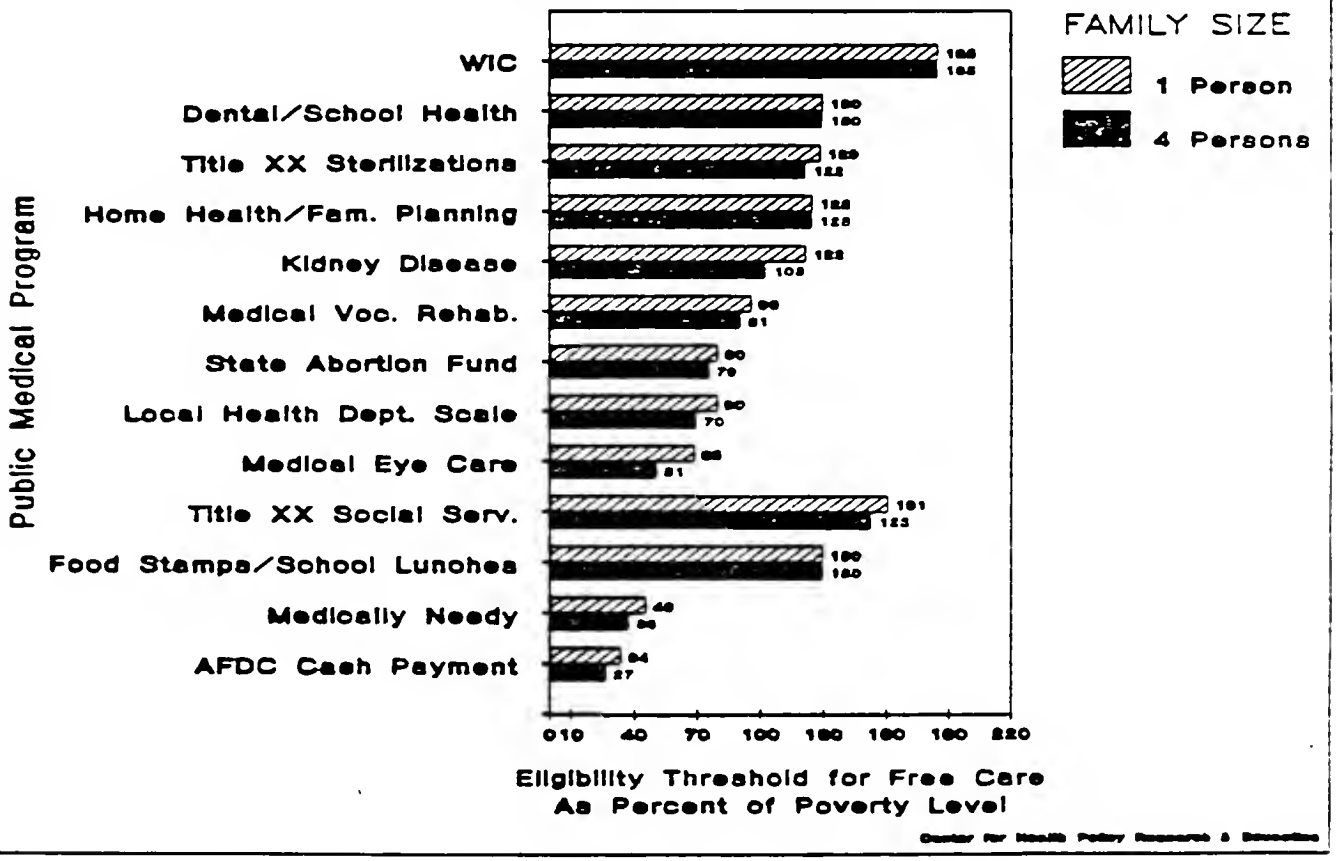
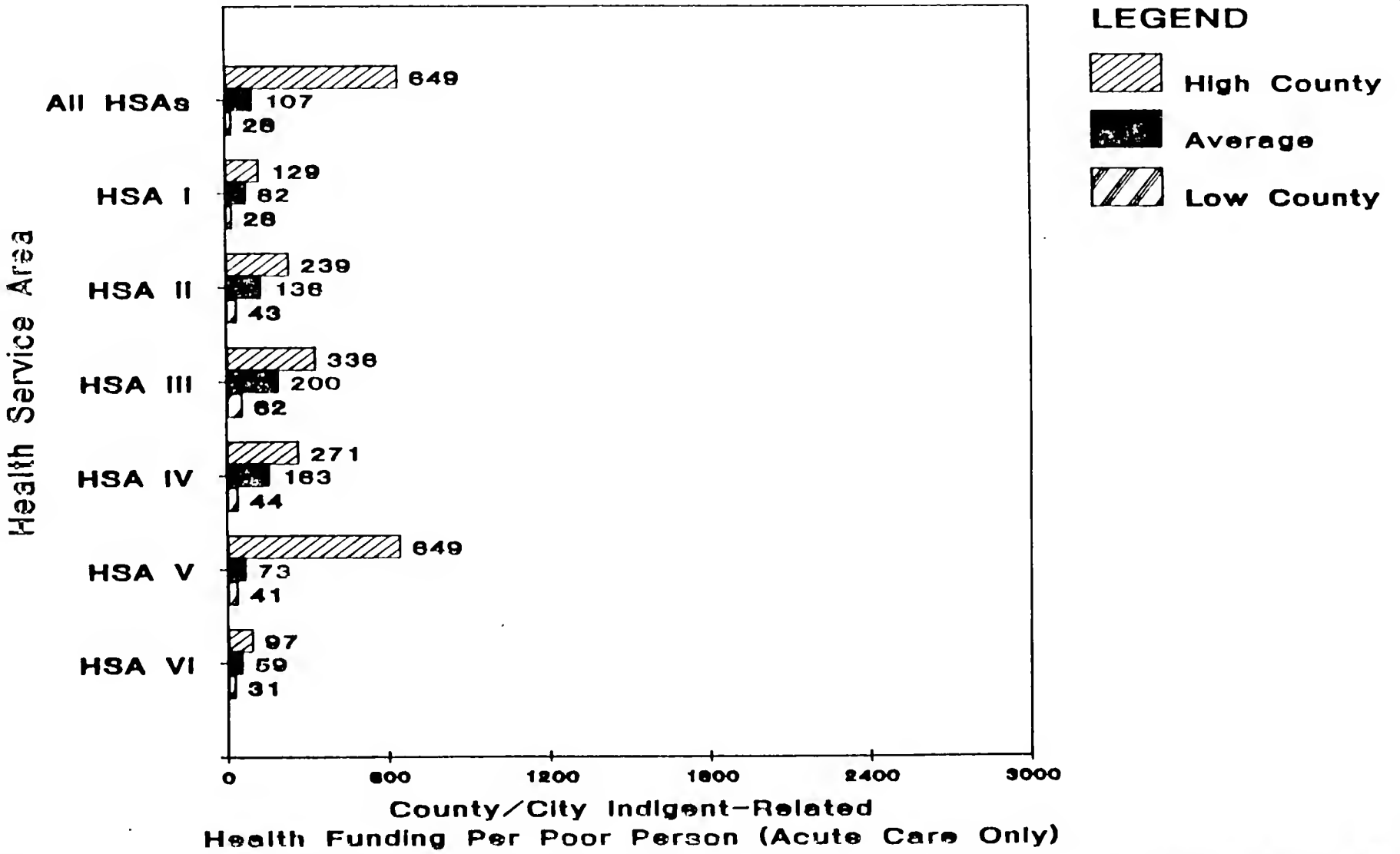
ELIGIBILITY THRESHOLDS FOR PUBLIC MEDICAL PROGRAMS, 1985



Comparative Availability of Public Funds For Indigent Health Care, 1985



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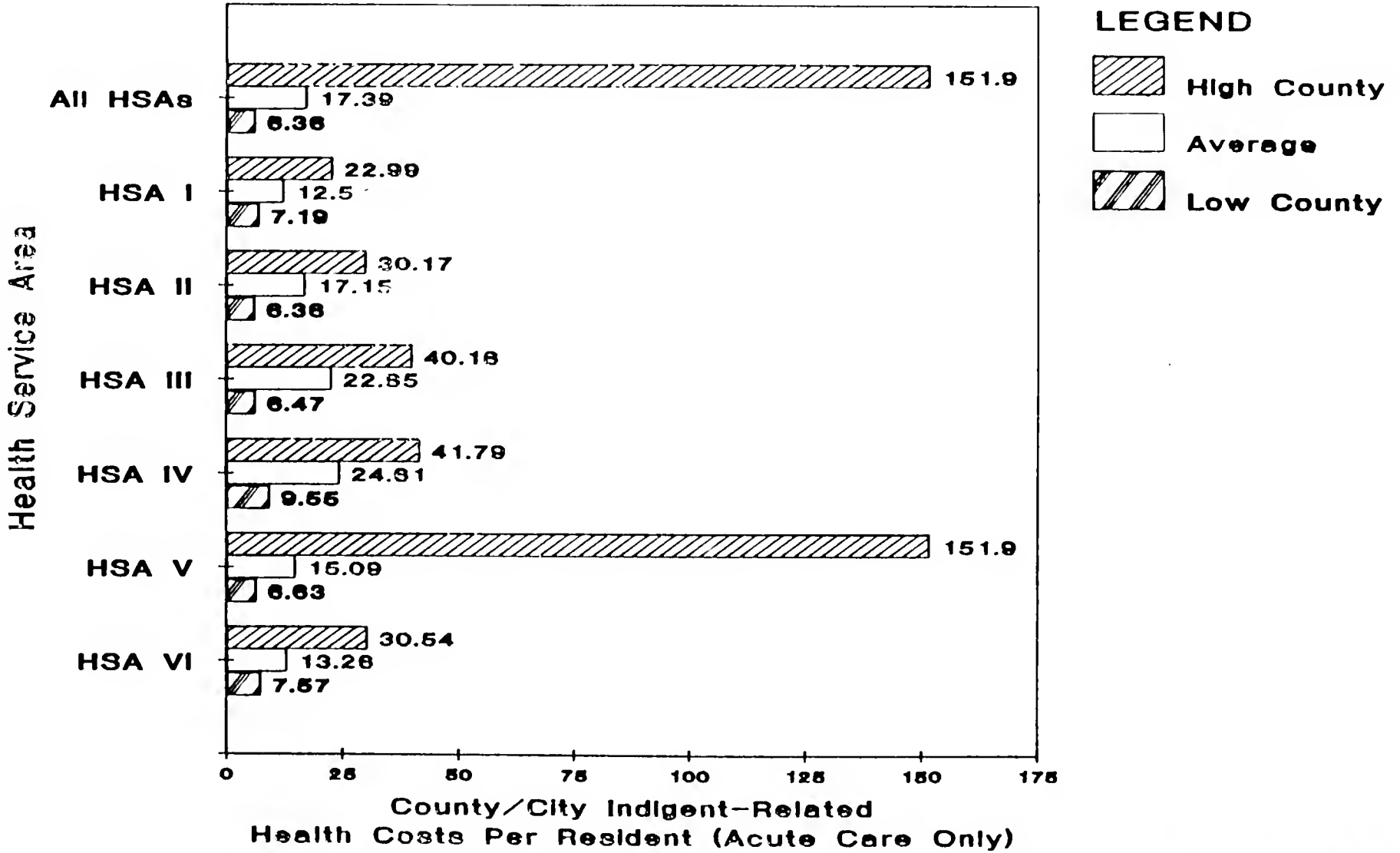
Comparative Financial Burden of Medically Indigent, 1985



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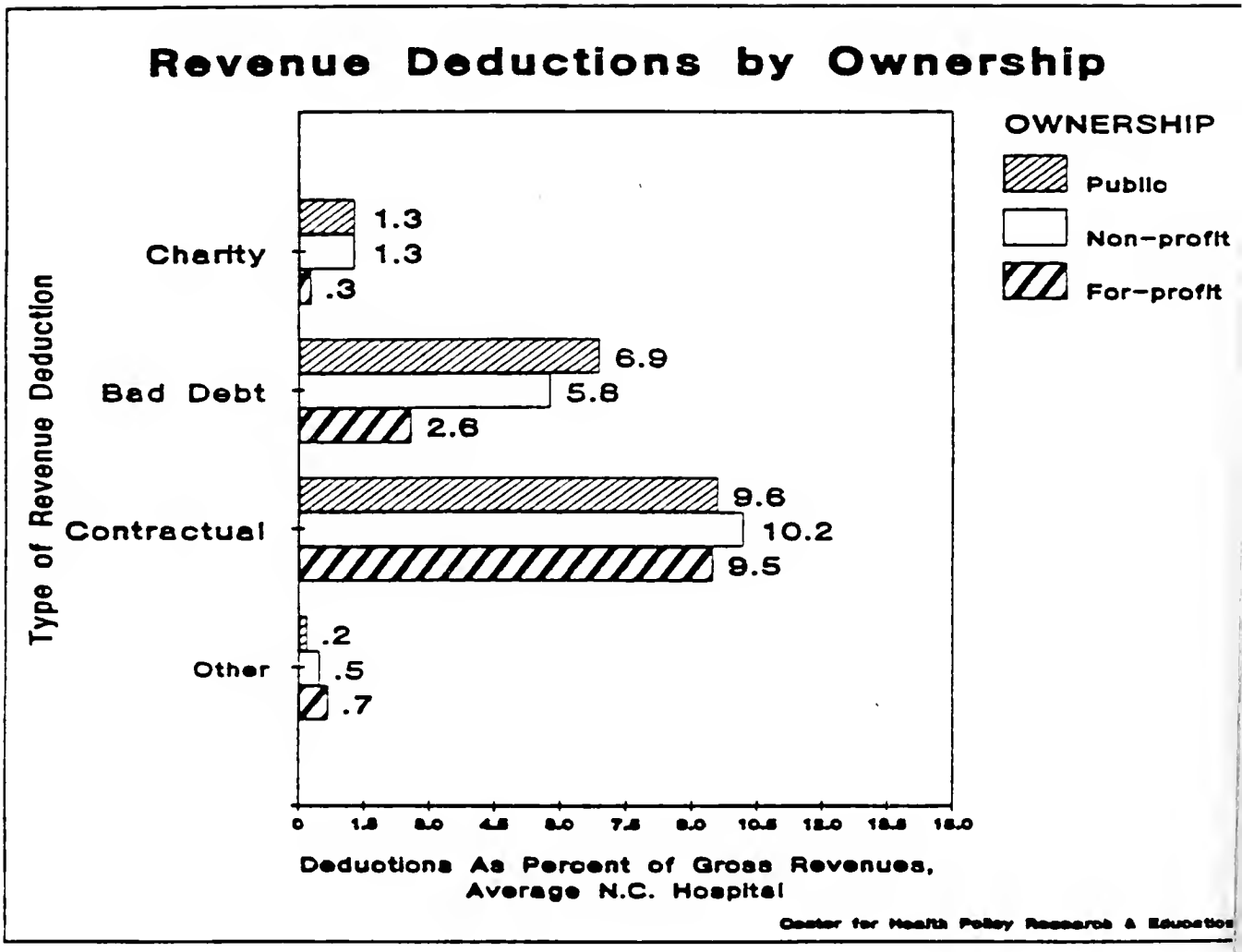
Revenue Deductions by Ownership
OWNERSHIP
Public
Non-profit
For-profit
Type of Revenue Deduction
Charity
1.3
1.3
.3
Bad Debt
6.9
5.8
2.6
Contractual
9.6
10.2
9.5
Other
.2
.5
.7
0
Deductions As Percent of Gross Revenues,
Average N.C. Hospital
Center for Health Policy Research & Education

Measuring the Burden of Hospital Uncompensated Care

Measure	Includes	Amount	Percent of Costs
Gross Deductions	All Uncompensated Care Charges	$412.0 m.	20.8 %
Adjusted Gross	Adjusted to Costs	$327.7 m.	16.6 %
Net Deductions	Deduct Revenue Offsets	$284.8 m.	14.4 %
Net Private	Charity & Bad Debt Costs Minus Offsets	$97.6 m.	4.9%

NOTE: Total Operating Costs in 1982 = $1,977.7 million.

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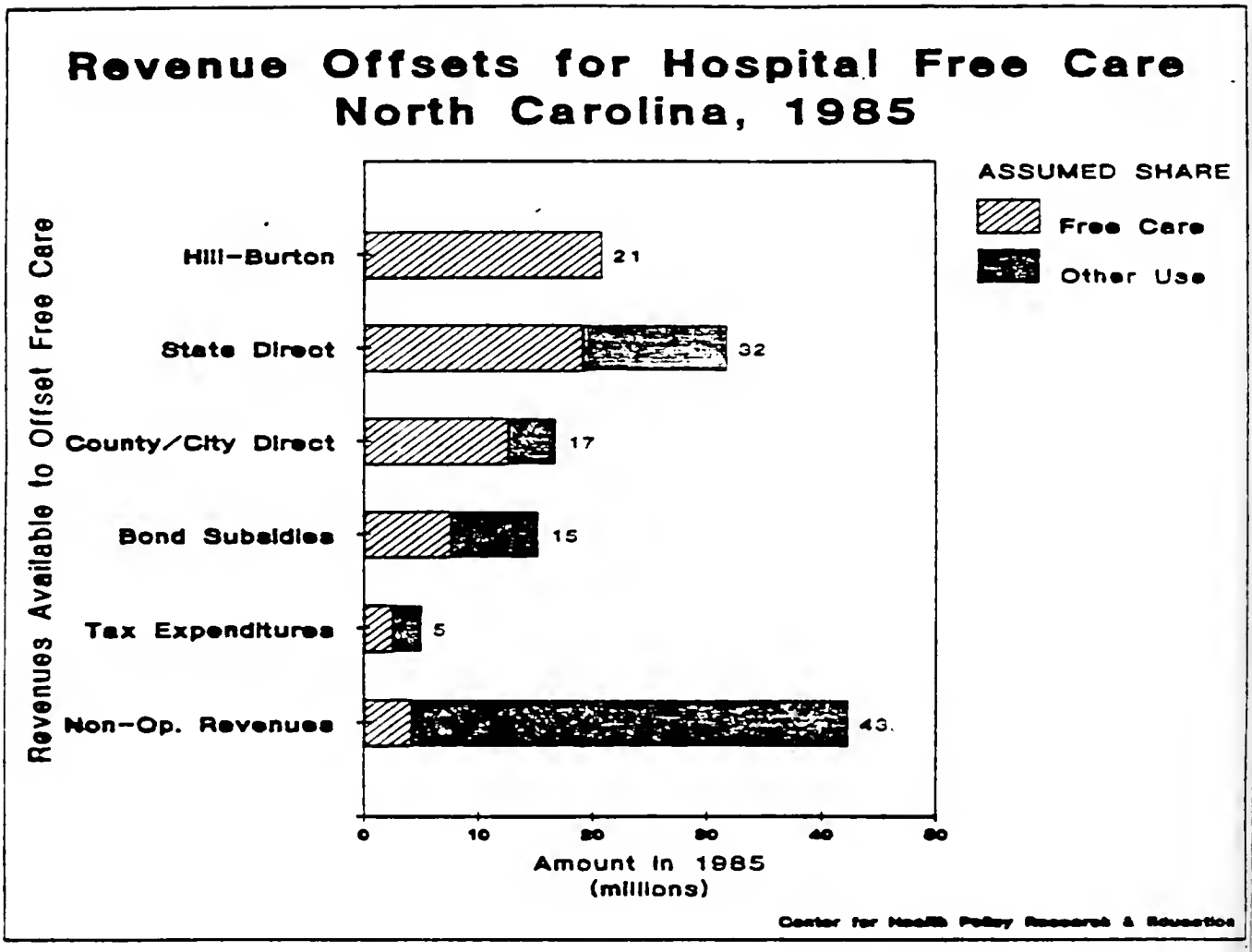
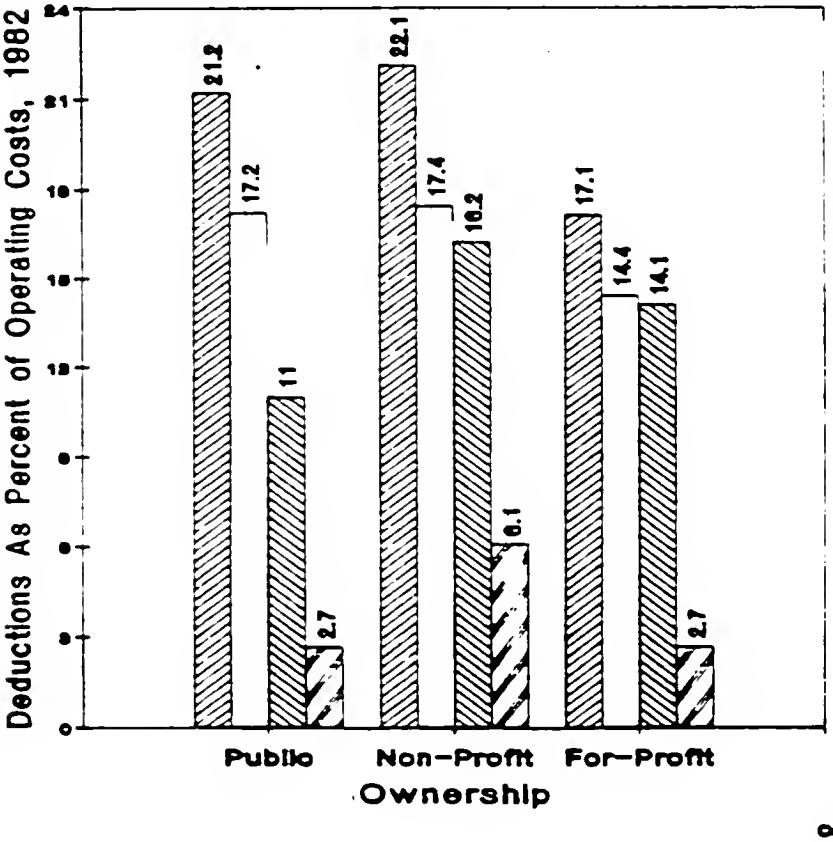

Revenue Offsets for Hospital Free Care
North Carolina, 1985
Revenues Available to Offset Free Care
Hill-Burton
State Direct
County/City Direct
Bond Subsidies
Tax Expenditures
Non-Op. Revenues
21
32
17
15
5
43
0
10
20
30
40
50
Amount in 1985
(millions)
ASSUMED SHARE
Free Care
Other Use
Center for Health Policy Research & Education

Uncompensated Hospital Care Burden
North Carolina, 1982



MEASURE OF BURDEN

- Gross Deductions
- Adjusted Gross
- Net Deductions
- Net Private

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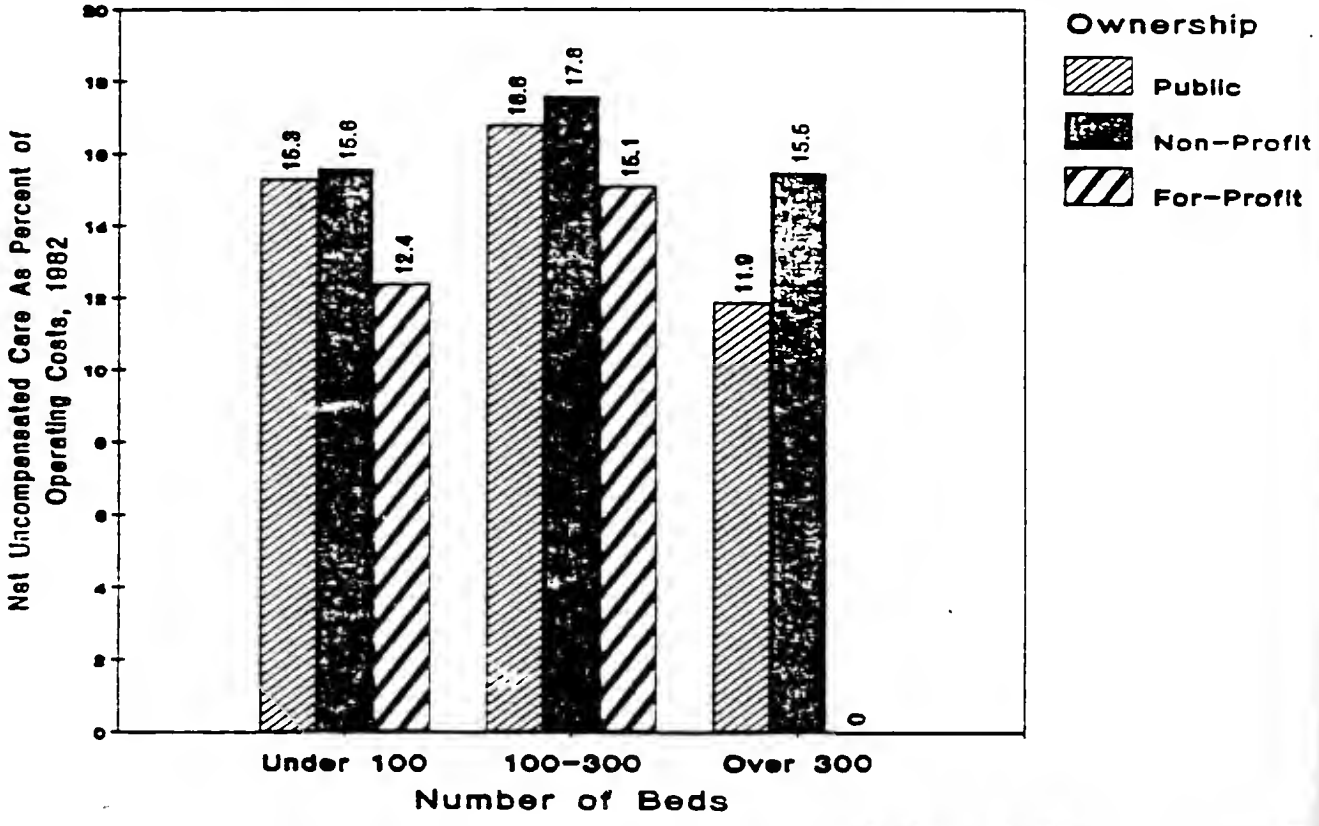
Distribution of Uncompensated Care By Hospital Size and Ownership



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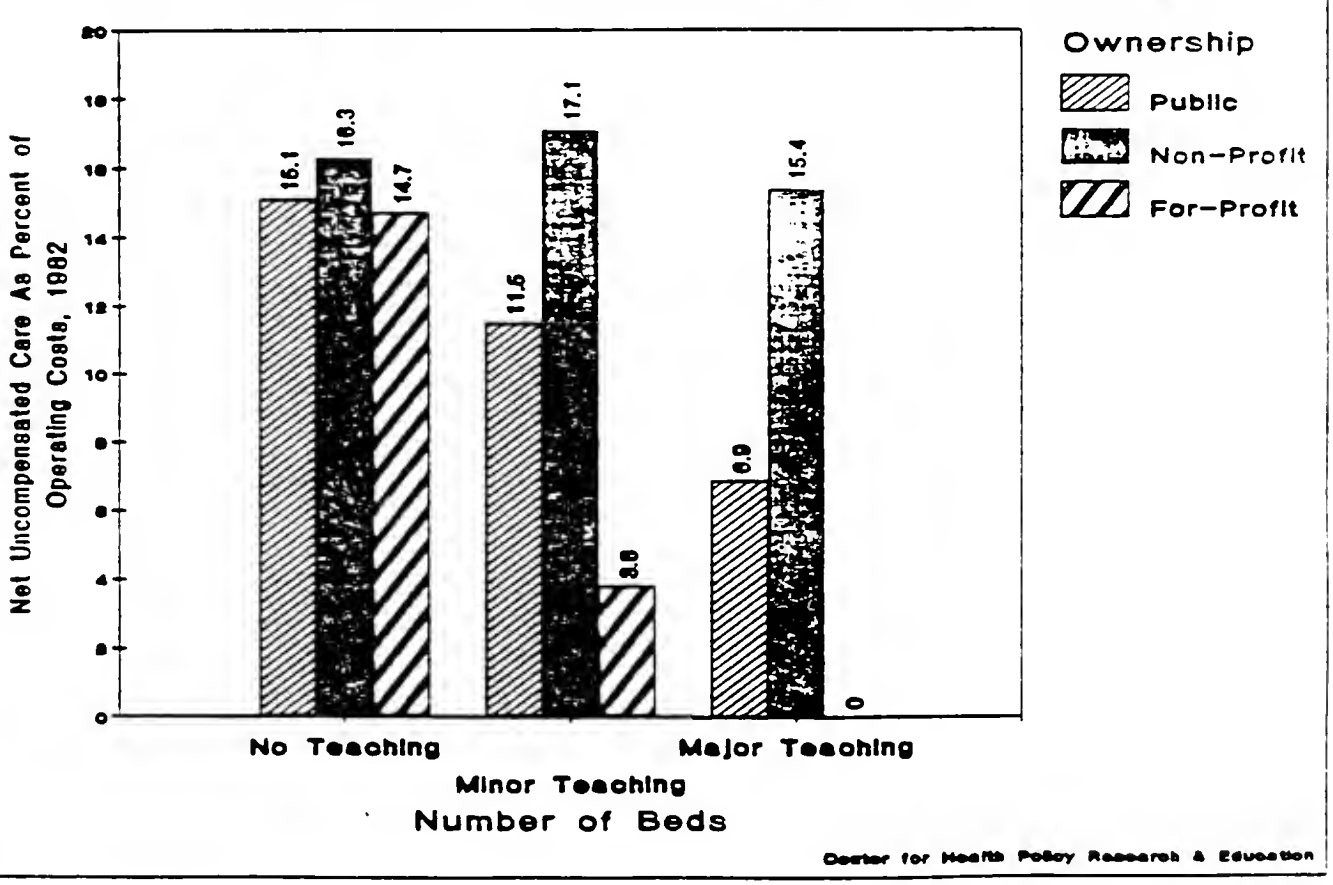
Distribution of Uncompensated Care By Teaching Status and Ownership



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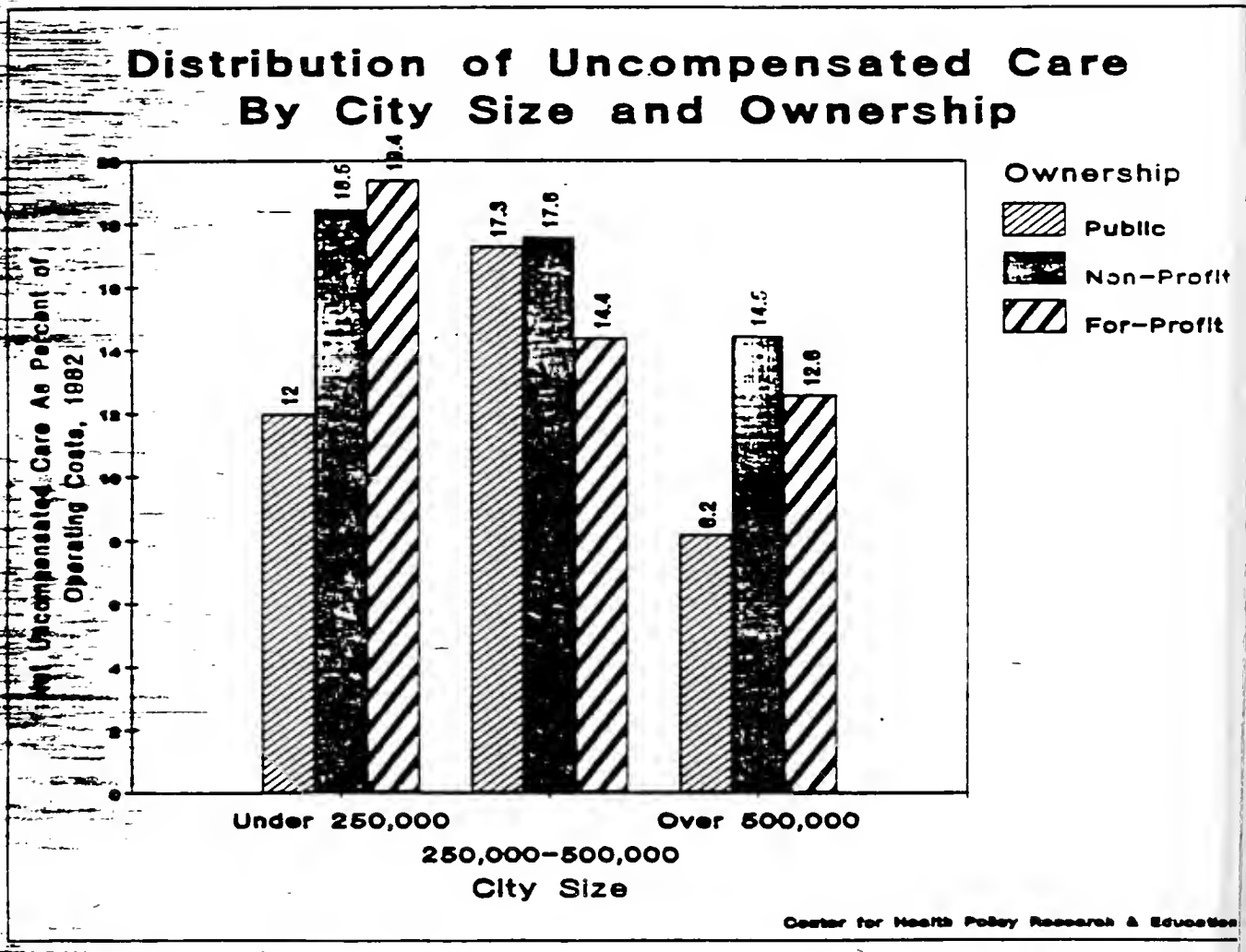
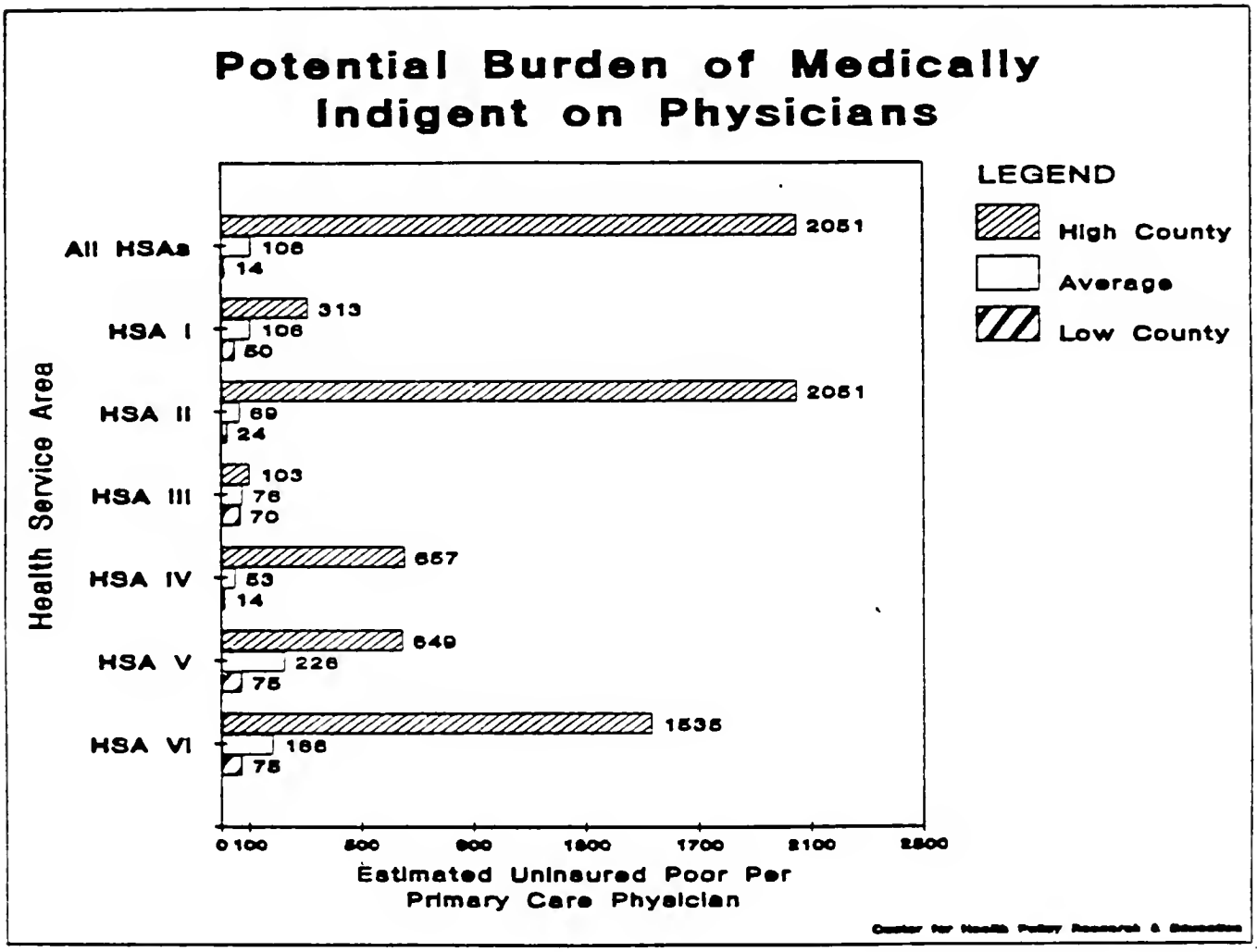

Distribution of Uncompensated Care
By City Size and Ownership
Ownership
Public
Non-Profit
For-Profit
Uncompensated Care As Percent of
Operating Costs, 1982
12
18.6
19.4
17.3
17.8
14.4
8.2
14.5
12.8
Under 250,000
250,000-500,000
Over 500,000
City Size
Center for Health Policy Research & Education


Potential Burden of Medically Indigent on Physicians
LEGEND
High County
Average
Low County
Health Service Area
All HSAs
HSA I
HSA II
HSA III
HSA IV
HSA V
HSA VI
2051
106
14
313
106
50
2051
69
24
103
76
70
657
53
14
649
226
75
1535
166
75
0 100
500
900
1300
1700
2100
2500
Estimated Uninsured Poor Per Primary Care Physician

General Legal Responsibility for Indigent Health Care

Responsibility for Indigent Health Care	Number of States	States
State	14	AK CO DE HW IL KS MD MA OR SC VT WA WV WY
County	19	AR CA FL GAoo ID IAoo LA MIoo MDoo MTOO NBoo NV NY ND OHoo OK PAoo SO UT
County Responsibility Unclear	2	AL TX
Counties Operating County Hospitals	4	CO NC TX WY
Towns	2	CT VT
State & County	5	AK GA MI NM VA
State & Towns	4	CT ME NJ RI
Counties & Towns	4	IN MN NH WI
No Unit Responsible	3	KY NC TN

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Contingent Obligations to Provide Indigent Health Care

- Hospital Care
  - Hill Burton
  - Certificate-of-Need
  - Teaching Hospitals
- Non-Hospital Care
  - Federal Health Centers
  - Rural Health Centers
  - National Health Service Corps

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INDIGENT HEALTH CARE

NORTH CAROLINA COUNTY PROFILES

Prepared for

INDIGENT HEALTH CARE STUDY COMMISSION

By

Center for Health Policy Research & Education
Duke University

August, 1986

Any questions regarding information contained
in this material may be directed to
Chris Conover, 684-4175

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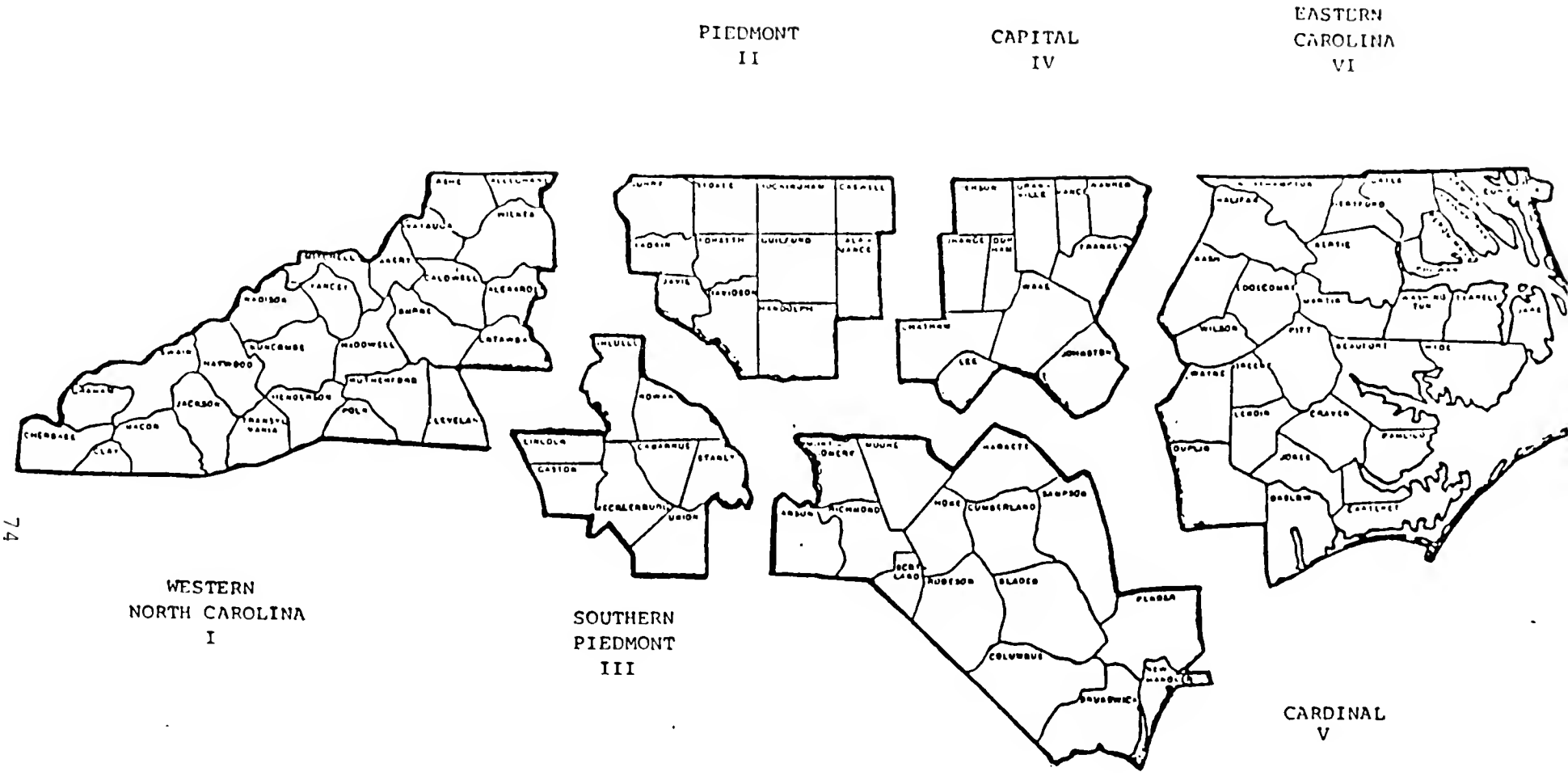

NORTH CAROLINA HEALTH SERVICE AREAS

SUMMARY:

INDIGENT HEALTH CARE IN NORTH CAROLINA COUNTIES

SUMMARY:
INDIGENT HEALTH CARE IN NORTH CAROLINA COUNTIES

The purpose of this compilation is to provide a comprehensive source of county data related to the problem of health care for the medically indigent. For the most part, these data summarize the picture as of 1985, representing the most recent available information. This report is divided into six different areas of interest. The following briefly reviews some highlights from each section.

GENERAL POPULATION CHARACTERISTICS

General Characteristics of North Carolina Counties (Table 1)

Counties vary enormously in size, ranging from over 400,000 persons living in Mecklenburg County to slightly more than 4,000 in Tyrrell County. The estimated number of persons with incomes below federal poverty guidelines also varies widely, from over 50,000 in Mecklenburg County to only 1100 in Tyrrell County. A more appropriate measure of how the burden of poverty varies across counties is to compare the percent of the population with incomes below poverty. In 1980, nearly 15 percent of the state population had below-poverty incomes, but this rate ranged as low as 8.2 percent in Catawba County to a high of over 30 percent in Warren County. Counties with the highest poverty rates are found predominantly in the far western and eastern parts of the state (HSAs I, V and VI).

Another measure of differences in prosperity across counties is per capita income, which ranges from as low as $6,759 in Hyde County to a high of nearly $15,000 in Mecklenburg County. Not surprisingly, there is a strong negative correlation between a county's poverty rate and its per capita income: counties with the highest poverty rates tend to have the lowest incomes. Finally, the unemployment rate across counties ranges from a low of 3.3 percent in Wake County to a high of nearly 18 percent in Graham County. Counties with the higest unemployment rates also tend to have the highest poverty rates and lowest per capita incomes. The unemployment rate also has an important effect on the number of persons without insurance, since compared to full-time workers, the unemployed are at least 3.5 times as likely to be without health insurance (based on Current Population Survey data for North Carolina).

Employment Status of Persons Age 16 and Older (Table 2)

The U.S. Bureau of Labor Statistics tends to measure all employment activity in terms of persons who are 16 or older since that is the group considered to be of working age. Statewide, about 60 percent of this group are employed (including part-time workers). However, in Tyrrell County, only 44 percent of this group is employed, compared to an employment rate of 70 percent in Onslow County.

Of those who are not working, the vast majority are not in the labor force--including students, spouses who stay at home, and retired persons. Statewide, slightly over one-third of persons 16 or older are not in the labor force, but this ranges from a low of 26 percent in Onslow County to a high of 50 percent in Northampton County. Counties in which a high fraction of working age persons are not in the labor force tend overwhelmingly to also have high poverty rates and low per capita incomes. As with unemployment, the number of persons not in the labor force is an important determinant of how many people are uninsured, since compared to full-time workers, the rate of being uninsured is three times higher among non-elderly adults who are not in the labor force.

Distribution of Employment by Type and Size of Employer (Table 3)

On average, over three-fourths of the workforce consists of private wage and salary workers, with the remainder made up of various types of government workers, self-employed persons and unpaid family workers (i.e., who work in family owned businesses such as farms). However, in certain counties (e.g., Orange, Jackson and Watauga), government accounts for a disproportionate share of workers.

The distribution of workers by size of employer is an extremely important determinant of insurance coverage, since smaller firms are much less likely than larger firms to offer health benefits. Compared to employees in firms with 1,000 or more workers, employees in firms with under 20 workers are more than four times as likely not have health coverage (this is based on a national study). Taking employment distribution into account, we estimate that the rate of being uninsured is probably almost 25 percent higher in Camden County than in the rest of the state, in large part because 89 percent of its workforce works for small employers. Moreover, counties with the highest fraction of workers in small firms also tend to have higher poverty rates. These counties tend to be concentrated in the far eastern and western parts of the state.

NUMBER AND CHARACTERISTICS OF MEDICALLY INDIGENT

Size of Medically Indigent Population (Table 4)

Statewide, roughly 40 percent of persons below poverty have no health insurance on an average day (398 uninsured poor per 1,000 poor). In some counties such as Hoke, however, this fraction rises to nearly 60 percent, compared to less than 20 percent in Forsyth. The number of uninsured poor is very nearly equal to the number of persons eligible for Medicaid (both statewide and in most counties). Not all persons on Medicaid are below poverty (statewide, about one fourth of Medicaid eligibles have incomes above poverty, evidently because they have had high medical expenses which allow them to qualify on the basis of "spend down"). However, as a rough guide to the fraction of persons below poverty who are Medicaid-eligible, we have computed Medicaid eligibles per 1,000 poor. Interestingly enough, however, there is almost no correlation between the number of Medicaid eligibles per 1000 poor and the number of uninsured per 1,000 poor. That is, unlike what we might expect, counties where the fraction of persons below poverty who qualify for Medicaid is the highest are not necessarily the same counties where the fraction of poor people who are uninsured is the lowest.

Statewide, the number of Medicaid eligibles has dropped nearly 10 percent during the past four years, mostly due to eligibility changes imposed by the Reagan administration in the early 1980's. Despite these changes, some counties have experienced relatively high growth in their Medicaid population, while in others, the decline in enrollment has been much more severe. For example, the number of Medicaid eligibles climbed by more than one-fourth in Perquimans County between 1981 and 1985, yet in that same period, eligibles dropped by over one-third in Alexander County.

Age Distribution of Medically Indigent (Table 5)

Statewide, 14 percent of the population is without health insurance on an average day. However, we estimate that in some counties, such as Chatham, the rate is less than 10 percent, whereas in other counties such as Warren, the rate is in excess of 25 percent (recall that Warren County also has the highest poverty rate in the state). Of those who are uninsured, nearly half (46 percent) have incomes below poverty. But again, this varies widely from a low

of 21.6 percent in Alexander County to a high of nearly 70 percent in Bertie and Halifax counties.

There is a strong association between the number of uninsured and the poverty rate, since the higher the poverty rate, the greater the number of uninsured poor (which, in turn, increases the total number of uninsured). The counties with the highest rates of being uninsured and the highest fraction of poor among their uninsured also tend to have the lowest per capita incomes. Table 5 also shows the age distribution of both the uninsured and uninsured poor populations.

Number of Medicaid and Medicare Eligibles By Category (Table 6)

On average, nearly three fourths of Medicaid eligibles receive Aid to Families with Dependent Children (AFDC) or are AFDC-related (they live in families with dependent children, but their income is slightly too high to qualify to receive any AFDC payments. Such individuals are still allowed to qualify for Medicaid). Generally, the elderly constitute one out of six Medicaid recipients, while the disabled account for slightly less than one out of 8. Some counties have a much different mix of eligibles, however. For example, in Avery County, only 41 percent of eligibles are on AFDC, nearly the same number are elderly, and almost one in five qualifies due to disability.

The Medicare population is nearly twice as large as the Medicaid population (only in some of the poorest eastern counties does the number of Medicaid eligibles nearly equal the number on Medicare). Among the Medicare population, nearly 90 percent are elderly, and the remainder are persons with permanent disabilities (who are generally, but not always, non-elderly). There is relatively little variation in this percentage across counties.

AVAILABILITY OF MEDICAL SERVICES

Distribution of Physicians, by Specialty (Table 7)

About half of all physicians in North Carolina can be categorized as primary care physicians, including those who specialize in family practice, general practice, internal medicine, obstetrics and gynecology, pediatrics, as well as those not Board-certified in any specialty. In over 10 percent of counties, primary care physicians constitute 100 percent of available physician manpower. There is only one county which currently has no practicing physicians (Tyrrell County, which is the smallest county in the state).

Availability of Primary Care (Table 8)

One rough way to compare differences in access to care across counties is to determine the number of persons per provider. Providers include both physicians as well as other mid-level practitioners such as physicians assistants and nurse practitioners (including nurse midwives). These mid-level practitioners are required to work under the supervision of a physician, but nevertheless represent an important additional source of care. Statewide, there are over 1,000 such mid-level practitioners, compared to roughly 4,200 primary care physicians.

On average, there is roughly 1 primary care provider per 1200 people, but this varies enormously by county. In Camden County, for example, there is a single physician for a population of nearly 6,000, whereas in Orange county there is one primary care provider per 243 people. This contrast highlights two limitations of these data. First, people can and do cross county lines for care. Second, the count of active manpower does not take into account whether

the provider is active in patient care. There are many Orange County physicians, for example, who are connected with the medical school and who devote only a small fraction of their time to patient care. If we could make the appropriate adjustments, the situation would not look quite a serious in Camden County or quite as rosy in Orange County. Nevertheless, population per provider ratios can serve as a rough guide for highlighting areas of relative need and abundance. Thus, for example, the eastern-most counties (HSAs V and VI) have over 1400 people per primary care provider, compared to less than 700 people per provider in the Piedmont area (HSA IV).

In terms of the indigent population, there are fewer than 200 poor persons per primary care provider statewide. But this ratio is as low as 40 poor per provider in Orange County to a high of 1300 poor per provider in Perquimans County. Similar differentials arise in comparing the number of uninsured poor persons per provider. Statewide, there are only 76 uninsured poor per provider, but this ranges from a low of 11 uninsured poor per provider in Orange County to more than 700 uninsured poor per provider in Perquimans County. Even with adjustments, it is safe to infer that the medically indigent in Perquimans County probably find it more difficult to obtain needed medical care than in Orange County and/or that the burden of uncompensated physician care is greater in the former than in the latter.

Availability of Inpatient Care (Table 9)

There are 17 counties which do not have any short-stay hospital facilities. Of the 83 remaining counties, over 60 percent have only one short-stay hospital, leaving 31 counties in which there are 2 or more facilities. Of more than 21,000 beds in use statewide, there are roughly equal numbers of beds operated by public and non-profit entities. For-profit facilities account for 7 percent of these beds, operating in only 10 different counties.

There are less than 300 people per short-stay bed in North Carolina. In Durham County, this ratio falls to only 123 people per bed, whereas in Onslow County, there are more than 800 per bed. As with the manpower data, there are limitations to such ratios. A UNC study, for example, found that even apart from the 17 counties without hospitals, there are 16 other counties in which more than one third of the population travels outside the county to obtain inpatient care.[1] It may be more meaningful to compare regional statistics. Thus, for example the eastern-most counties have nearly 50 percent more people per bed compared to the Piedmont, but the number of poor people per bed is more than twice as high in the east compared to the Piedmont. Moreover, the number uninsured poor per bed is nearly three times as high as the number found in the Piedmont. These disparities occur because not only is the relative size of the medically indigent problem larger, but there are also relatively fewer health services available in the eastern counties.

As a consequence, the relative burden of uncompensated hospital care is greater in the east (based on 1982 AHA data for North Carolina). For example, as a percent of hospital expenses, the cost of charity and bad debts (minus revenues that can be used to offset such costs) is nearly 40 percent higher in HSAs V and VI compared to the average hospital in the state (because the data are confidential, we cannot report them by individual hospital or county). In

[1] Eleanor Blakely et al., Geographic Distribution of the Medically Uninsured Poor and of Inpatient Care Patterns in North Carolina (Chapel Hill: University of North Carolina at Chapel Hill, March 1986).

fact, hospitals in HSAs V and VI account for about one fourth of hospital charges in the state, but incur nearly 40 percent of the charity and bad debt burden.[1] These same counties account for 44 percent of the poverty population and over half of the uninsured poor population.

Uncompensated care may also affect competition among hospitals within the same county. Using 1982 data, we computed the total increase in charges to private full-pay patients that can be accounted for by uncompensated care from all sources.[2] In each county which had hospitals in competition, we then compared the difference in average charges per day (for all patients) to determine whether the elimination of cost-shifting would allow this differential to narrow (meaning competition would increase, all other things being equal) or widen. In over one fifth of counties (7 of 32), we found that the elimination of cost-shifting would reverse the competitive position of the hospitals involved.[3] That is, the hospital which previously had the highest charges would be able to charge less than its competitor if cost-shifting were eliminated. All told, elimination of cost-shifting would improve competition in over two-thirds of counties (21 of 32), would produce mixed results in 6 other counties (with 3 or more hospitals competing) and would worsen competition in 16 percent of counties (5 of 32). That is, in these latter counties, the difference in charges between hospitals would theoretically

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[1] The charity and bad debt burden is measured as follows. Total deductions for charity and bad debts are adjusted to costs by multiplying by the ratio of costs to charges (in most hospitals, actual costs are roughly 20 percent below charges). From this are deducted offsets such as tax revenues, Hill-Burton charity care obligations and 10 percent of other non-operating revenues (e.g., charitable contributions, grants, interest earnings, etc.). This net cost of charity and bad debts is then divided by patient expenses to yield a ratio that averages 5.4 percent statewide.

[2] The amount of cost-shifting per private paying patient was computed as follows. Total deductions from revenue for charity, bad debts, and contractual allowances were adjusted to costs and revenue offsets were deducted (as described above). The residual was divided by patient days attributable to private patients (which was estimated by multiplying total patient days by a ratio. This ratio equals:

(GROSS - MCD - MCR - CH - BD - OTHER)/GROSS

where GROSS equals total gross patient revenues, MCD equals gross revenues from Medicaid patients, MCR equals gross revenues from Medicare patients, CH equals gross revenue deductions due to charity, BD equals gross deductions for bad debts, and OTHER equals gross deductions for contractual allowances (exclusive of Medicaid/Medicare contractual allowances). This yields a rough estimate of the total patient days accounted for by patients who paid full charges.

[3] All statements regarding hospital competitive position presume that if cost-shifting were eliminated, all hospitals would lower their charges to private patients. In the real world, hospitals may not respond by lowering charges. For example, one respected theory of hospital behavior argues that hospitals now set their charges so as to maximize revenues and then provide whate er level of uncompensated care can be afforded within the surplus revenues which result from this strategy. If so, elimination of cost-shifting would simply increase hospital profits rather than reduce charges to private patients.

increase if cost-shifting were eliminated.

Availability of Alternative Delivery Systems (Table 10)

In recent years, alternative delivery systems such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) have spread rapidly in North Carolina. Based on the counties in which existing alternative delivery systems now are operational, we have found that nearly two thirds of the uninsured poor population live within those counties. Not surprisingly, however, the counties in which such systems have not yet been marketed consist predominantly of low-income counties in the western and eastern parts of the state. For example, existing alternative delivery systems are available in virtually all counties in the central portion of the state (HSAs II, III, IV), but are capable of reaching less than 60 percent of the uninsured poor living in the west (HSA I) and less than half of those living in the east (HSAs V and VI).

In many cases, there exist public clinics or local health departments which in principle might be organized as alternative delivery systems--either by changing the method of reimbursement (e.g., from fee-for-service to prepayment) or the organization of care (e.g., designating a primary care "gatekeeper" responsible for ensuring that inpatient and specialty care are coordinated and appropriate). These potential alternative delivery systems are well enough dispersed that they could cover nearly 70 percent of the uninsured poor. Although this clearly represents some overlap with existing systems, it is important to recognize that there are 32 additional counties which could be served through these potential systems which are not now being reached by existing systems. As a consequence, if both existing and potential systems are considered, nearly 90 percent of the uninsured poor could in theory be served by alternative delivery systems.

Total Expenditures for Indigent-Related Health Care, 1985 (Table 11)

Statewide, over $1.5 billion in publicly subsidized medical services are provided to citizens of North Carolina (exclusive of Medicare, which is another major source of health funding for low income persons). Data do not exist to permit a reliable estimate of physician free care by county and confidentiality concerns preclude our reporting on the total amount of hospital bad debts and charity care by county. Together, such free care accounted for $370 million of the $1.5 billion total. In addition, there is $240 million spent on various programs (e.g., VA health services, state mental hospitals, neonatal intensive care payments, etc.) which could not be reliably apportioned back to individual counties. This leaves nearly $900 million that can be reported by individual counties, of which over half comes from the federal government and an additional one third is from the state. The remainder is paid by counties or other local units of government.

In terms of services provided, over one-third ($325 million) represents long term care services paid by Medicaid. Medicaid accounts for about 60 percent of the remaining $550 million in acute care services. Of this $550 million, the largest single fraction ($43 million) is spent in Mecklenburg County, while the smallest amount ($374,000) is spent in Camden County.

Indigent-Related Health Funding Available for Persons Below Poverty (Table 12)

One way to compare counties is to divide total health outlays by the number of people below poverty. This is not a perfect measure, since some of the funds (e.g., subsidies for ambulance services) may benefit all persons, not just

those below poverty. However, it does serve as a rough gauge of the amount of publicly subsidized health care available compared to an important population group in need.

Excluding long term care services, the average county spends just over $100 per year in county funds per person below poverty. The total amount of funds per person for acute care services amounts to $549 (this sounds like a very large amount, but remember that 60 percent of these amounts are for Medicaid recipients and that on an average day, only 25 percent of poor are enrolled in Medicaid). Yancey County spends the least per poor person ($26 local dollars), while Pender County spends the most ($645).

Statistical analysis reveals some interesting patterns in county funding per poor person. For example, although there is some tendency for higher income counties to contribute more per poor person, the following is also true. First, counties which spend more per poor person also tend to spend a higher share of per capita income on subsidized health services. Similarly, the amount spent per local resident is higher in counties where the local funding per poor person was the highest. Third, counties which own hospitals also tend to spend more per poor person. In short, it is not just that wealthier counties can afford to spend more on a problem that is relatively small. It is also the case that counties where local funding per poor person is the greatest also appear willing to incur a higher burden on local residents (measured in terms of amount spent per $10,000 in personal income or in terms of amount spent per resident).

Total funds per poor person are highest in Stanly County, amounting to over $2200 per year (with Medicaid accounting for three-fourths of this amount), compared to only $197 in total funds per poor person in Currituck County. Not surprisingly, counties with high total amounts per poor person also tend to have higher amounts of local dollars per poor person as well. However, if we look separately at <u>non-local</u> funds per poor person, this relationship disappears. That is, counties which do invest greater amounts of their own resources per poor person are not rewarded by greater amounts from other sources (nor, however, are they penalized by experiencing a reduction in funds from other sources in response to their greater efforts). Non-local funds are not necessary targeted at counties most in need. That is, counties with high per capita incomes receive somewhat larger amounts of non-local health funds per poor person. Conversely, counties with high poverty rates tend to receive fewer non-local funds per poor person.

<u>Comparative Public Burden of Indigent Health Care, 1985 (Table 13)</u>

There are several different ways to measure the relative willingness of counties to undertake the burden of financing indigent health care. One possibility is to compare each county's share of the total amount of indigent-related health funding available. On average, counties contribute only about 14 percent of all indigent-related health funds. In Stanly County, however, local funds account for less than three percent of the total, whereas in Pender County, local funds make up more than half of the total. Counties which contribute a disproportionate share of the total also tend to devote higher-than-average amounts of local funds per poor person.

Indigent-related funding by local governments amounts to nearly $17 per $10,000 of personal income (i.e., less than two-tenths of one percent). In only one county (Pender) does this share of income rise above one percent. In contrast,

in Cabarrus County, the amount per $10,000 income is less than half of the statewide average. Counties which contribute higher-than-average amounts relative to their income tend to have higher poverty rates and lower per capita incomes.

One final measure of burden is total amount of local funding per resident, which averages over $19 per capita statewide. In Pender County, this totals more than $150 per resident, whereas in Randolph County, the total burden is less than $7.50 per resident. Each of these three different measures of burden correlates closely with each other. That is, counties which absorb a higher than average share of the funding burden also spend higher than average amounts per $10,000 income and per resident.

TRENDS IN PUBLIC INDIGENT-RELATED HEALTH EXPENDITURES

Trends in Indigent Health Care, North Carolina Memorial Hospital (Table 14)

In 1985, North Carolina Memorial Hospital incurred nearly $17 million in indigency write-offs, representing patients from all but two of the 100 counties in the state. These write-offs amounted to less than $2.50 per resident in the average county. But this ratio varies from a low of only one cent per resident in Swain and Yancey counties to as much as $28 per resident of Chatham County. Not surprisingly, this ratio is highest for counties which are geographically closest to Chapel Hill (HSAs IV and V). However, for the most part, this simply represents the larger number of people from these counties who happen to use NC Memorial for care. For example, on average, the write-offs amount to 13.2 percent of gross revenues (i.e., roughly speaking, charges). In the Piedmont (HSA IV), write-offs per capita are more than three times as high as the statewide average, yet write-offs as a percent of gross revenues amount to only 13.4 percent--almost identical to the state average. In these geographically proximate counties, a somewhat higher share of the write-offs can be attributed to outpatient services.

Compared to other counties, the amount of write-offs per resident is roughly the same in counties with county-owned hospitals, so there does not appear to be a tendency of counties to dump their indigent problem onto a state-owned facility. More surprising, the degree of poverty has little relationship to the total amount of write-offs per resident, so again, there does not appear to be a problem of residents from relatively poor counties having to disproportionately rely on a state facility. Moreover, counties with higher-than-average write-offs tend to spend more per poor person on health care compared to other counties.

Trends in County/City Direct Appropriations to Hospitals (Table 15)

Nearly half (47) of all counties own short-stay hospitals; an additional 5 counties have facilities owned by other levels of government or quasi-governmental bodies (e.g., cities, townships, or special hospital districts). Of the 52 total counties with publicly owned facilities, however, more than half (31) allow a non-profit or for-profit firm to manage daily operations. There are 24 counties in which local units of government made direct payments to hospitals in 1986. Of these, most (16) were counties with publicly owned facilities.

These payments include specific appropriations for indigent care, as well as general operating subsidies, county payments for ambulance services, etc. Therefore, the full amount cannot be attributed exclusively to care for indigents, but much of it can be. The total amount of such payments is

substantial, amounting to nearly $20 million in 1986. This is an increase of nearly one-third compared to similar payments made in 1984, but some counties have experienced as much as a 9-fold increase in such outlays during that same period.

Trends in Long Term Indebtedness of County Hospitals

Aside from direct payments to hospitals, counties indirectly subsidize hospitals by subsidizing long term debts such as general obligation bonds and revenue bonds. In 1986, all but 10 of the 47 county-owned hospitals had some sort of long-term debt. In all but 7 of the 37 counties with long-term debts, the county paid at least some portion of the annual debt service (in 15 counties, the county pays the full amount of long-term debt service on behalf of the hospital). On average, 60 percent of the long-term debts of publicly owned facilities are budgeted to be paid by local units of government, compared to only 46.5 percent in 1985.

SOURCES OF REVENUE FOR PUBLIC INDIGENT-RELATED HEALTH EXPENDITURES

The remaining tables in this report consist primarily of raw dollar figures used to compile totals reported in previous tables. Nevertheless, these tables too shed some insight on the distribution of the burden of subsidizing medical care for the indigent across different levels of government. For example, Table 17 shows total city/county funds in 1985, broken down by program. Of over $100 million in indigent-related health funding provided by local governments in 1985, nearly half is for area mental health programs, less than one-third is for Medicaid, and a similar amount is for payments to hospitals (both direct and for long-term debt payments). Only 7 percent is for public programs such as those in local health departments.

In contrast, the distribution of state and federal dollars shown in Table 18 is quite different. Of more than $750 million in such funds, fully 80 percent is accounted for by Medicaid. Mental health programs account for only 1 in 8 state and federal dollars. The amount for public programs, such as local health departments is only 3 percent of the total shown, but remember that a large fraction of these costs was excluded because amounts could not be apportioned back to individual counties.

SUMMARY

Severe disparities dominate the picture of indigent health care at the county level. There are sharp differences across counties in the relative size of the problem (measured either in terms of people or dollars), the amount of resources available to deal with the medically indigent, and the amount of dollars from all sources available to assist those who cannot pay.

There are major differences in the relative level of fiscal effort exerted by different counties to provide health care for those who cannot afford it as well as inequities in the local per capita tax burden of financing such care. Generally, those counties which have invested the highest dollar amount of subsidized care per indigent also have the highest tax burdens attributable to indigent health care.

GENERAL POPULATION CHARACTERISTICS

General Characteristics of North Carolina Counties

Employment Status of Persons Age 16 and Over

Distribution of Employment by Type and Size of Employer

Table 1

GENERAL CHARACTERISTICS OF NORTH CAROLINA COUNTIES

COUNTY	1985 POPULATION All Persons	1985 POPULATION Below Poverty	1980 POVERTY RATE	RANK	1985 PER CAPITA INCOME	RANK	1984 UNEMPLOYMENT	RANK
STATE TOTAL	6,229,062	1,009,052	14.8%		11,411		6.8%	
HSA I	1,070,665	161,922	13.8%		10,541		7.4%	
Alexander	26,875	2,553	8.8%	99	10,821	33	5.9%	79
Allegheny	10,032	2,144	19.6%	39	9,266	67	10.0%	20
Ashe	23,547	5,841	22.8%	21	8,198	88	9.7%	25
Avery	15,084	2,973	18.0%	46	8,461	86	8.6%	41
Buncombe	167,299	23,601	12.9%	74	11,634	16	6.7%	67
Burke	75,539	8,330	10.1%	92	10,559	37	5.9%	80
Caldwell	68,556	7,758	10.4%	89	10,067	47	6.8%	63
Catawba	112,088	10,078	8.2%	100	12,552	7	5.6%	87
Cherokee	20,169	4,887	22.2%	23	7,473	98	13.8%	4
Clay	7,152	1,772	22.8%	20	7,754	94	9.9%	21
Cleveland	84,549	12,195	13.2%	73	10,297	42	8.9%	36
Graham	7,105	1,511	19.6%	40	7,990	91	17.9%	1
Haywood	47,469	8,096	15.6%	59	10,502	39	10.5%	16
Henderson	66,304	8,878	12.3%	78	12,239	8	6.0%	74
Jackson	27,635	5,811	19.3%	42	9,088	72	9.4%	31
Macon	23,528	4,365	17.2%	52	9,488	62	6.7%	64
Madison	17,107	4,787	25.8%	8	8,111	89	7.5%	50
McDowell	36,813	4,724	11.8%	79	9,841	53	9.5%	29
Mitchell	14,295	2,615	16.8%	55	9,382	64	9.6%	27
Polk	14,777	2,209	13.7%	68	11,939	13	6.4%	71
Rutherford	57,032	8,505	13.7%	71	10,041	48	9.2%	33
Swain	10,954	3,090	25.9%	7	7,891	92	15.9%	3
Transylvania	25,217	3,534	12.9%	75	11,100	26	4.9%	95
Watauga	34,973	8,584	22.7%	22	8,811	80	5.3%	93
Wilkes	61,045	9,114	13.8%	67	10,564	36	5.4%	92
Yancey	15,521	3,966	23.4%	18	7,658	95	9.8%	24
HSA II	1,166,477	146,087	11.5%		12,635		6.3%	
Alamance	102,475	11,617	10.4%	88	11,957	11	7.2%	53
Caswell	22,326	4,732	19.5%	41	7,589	96	8.3%	42
Davidson	118,179	13,680	10.6%	85	11,197	23	6.2%	72
Davie	27,834	3,294	10.9%	84	11,456	20	6.0%	75
Forsyth	258,323	32,760	11.6%	80	14,753	3	5.4%	89
Guilford	327,959	39,896	11.1%	82	13,878	4	5.4%	91
Randolph	97,258	9,457	8.9%	98	10,988	28	5.6%	86
Rockingham	86,323	12,132	12.8%	76	10,879	30	9.4%	30
Stokes	35,597	4,880	12.6%	77	10,007	49	7.7%	47
Surry	60,447	9,035	13.7%	70	10,884	29	8.7%	40
Yadkin	29,756	4,603	14.3%	63	10,655	34	7.1%	59
HSA III	1,063,606	121,421	10.4%		12,854		5.7%	
Cabarrus	93,133	9,495	9.3%	96	12,061	10	7.4%	51
Gaston	170,262	19,544	10.5%	87	11,247	21	6.4%	69
Iredell	86,783	9,588	10.1%	91	11,005	27	6.4%	70
Lincoln	44,798	4,733	9.7%	95	10,849	31	7.1%	55
Mecklenburg	437,898	52,552	10.9%	83	14,964	1	4.6%	96
Rowan	103,020	10,989	9.7%	94	11,524	18	5.7%	85
Stanly	49,608	5,708	10.5%	86	11,162	25	7.1%	58
Union	78,104	8,812	10.3%	90	11,504	19	5.4%	90
HSA IV	886,661	133,171	13.9%		12,725		4.7%	
Chatham	35,285	3,505	9.1%	97	11,210	22	6.0%	78
Durham	160,935	24,787	14.0%	65	13,405	5	3.6%	98
Franklin	32,049	7,076	20.3%	32	8,999	76	7.1%	60
Granville	36,909	6,985	17.3%	50	9,081	73	6.9%	62
Johnston	74,899	14,648	17.9%	47	9,510	59	6.0%	77
Lee	39,705	5,903	13.5%	72	11,957	12	8.8%	38
Orange	81,777	13,355	15.1%	62	12,970	6	3.5%	99
Person	30,477	5,537	16.6%	56	9,660	57	9.6%	28
Vance	38,245	8,842	21.0%	28	9,824	55	10.6%	15
Wake	340,202	37,090	10.0%	93	14,843	2	3.3%	100
Warren	16,178	5,441	30.5%	1	8,616	83	9.9%	23

COUNTY	1985 POPULATION All Persons	Below Poverty	1980 POVERTY RATE	RANK	1985 PER CAPITA INCOME	RANK	1984 UNEMPLOYMENT	RANK
HSA V	948,060	197,644	18.9%		9,546		9.2%	
Anson	26,551	4,679	16.1%	57	8,992	78	7.8%	46
Bladen	30,932	8,676	25.6%	9	8,062	90	12.9%	5
Brunswick	44,272	9,651	19.8%	37	8,806	81	11.4%	10
Columbus	52,096	15,127	26.5%	6	8,299	87	11.4%	9
Cumberland	255,453	49,098	17.2%	53	10,205	43	7.6%	48
Harnett	63,221	13,437	19.3%	43	8,556	85	7.1%	57
Hoke	22,884	5,321	20.9%	30	6,953	99	10.8%	13
Montgomery	23,828	3,702	14.2%	64	9,502	60	6.0%	73
Moore	54,722	8,187	13.7%	69	11,747	14	7.1%	56
New Hanover	112,565	18,714	15.2%	61	11,576	17	8.8%	39
Pender	24,114	5,642	21.3%	26	8,659	82	11.9%	7
Richmond	45,347	7,553	15.2%	60	9,209	69	10.2%	19
Robeson	107,243	29,561	24.9%	12	7,812	93	11.4%	11
Sampson	50,636	11,805	21.2%	27	9,327	66	9.1%	35
Scotland	34,196	6,490	17.3%	51	9,490	61	8.9%	37
HSA VI	1,093,593	248,806	20.8%		10,107		8.0%	
Beaufort	43,168	9,964	21.0%	29	10,163	45	7.9%	44
Bertie	21,590	6,983	29.4%	3	9,066	74	10.2%	18
Camden	5,917	1,041	16.1%	58	8,863	79	5.7%	84
Carteret	48,162	7,346	14.0%	66	9,614	58	6.7%	66
Chowan	12,960	3,420	24.0%	16	9,364	65	5.7%	83
Craven	76,955	15,806	18.5%	44	10,837	32	5.8%	82
Currituck	13,519	2,727	18.3%	45	9,118	71	5.4%	88
Dare	16,583	2,026	11.3%	81	9,212	68	7.2%	52
Duplin	41,483	10,476	23.1%	19	9,012	75	10.4%	17
Edgecombe	58,329	13,013	20.2%	33	9,962	51	9.6%	26
Gates	9,184	1,995	19.7%	38	9,837	54	4.4%	97
Greene	16,757	4,695	25.3%	10	9,781	56	7.2%	54
Halifax	56,222	18,288	29.5%	2	8,578	84	11.6%	8
Hertford	23,965	6,411	24.3%	14	9,414	63	9.1%	34
Hyde	6,013	1,871	28.3%	4	6,759	100	12.2%	6
Jones	9,840	2,340	21.8%	24	8,999	77	6.7%	65
Lenoir	61,268	13,410	19.9%	36	10,606	35	9.3%	32
Martin	26,567	7,042	24.1%	15	10,173	44	9.9%	22
Nash	70,912	15,507	19.9%	35	12,130	9	7.5%	49
Northampton	22,253	6,883	28.1%	5	7,507	97	11.1%	12
Onslow	121,891	23,198	16.9%	54	10,095	46	5.1%	94
Pamlico	10,792	2,423	20.6%	31	10,003	50	7.0%	61
Pasquotank	28,884	5,604	17.7%	49	10,552	38	5.9%	81
Perquimans	9,905	2,657	24.4%	13	9,190	70	6.4%	68
Pitt	97,164	25,046	23.5%	17	10,312	41	6.0%	76
Tyrrell	4,171	1,146	25.2%	11	11,179	24	17.1%	2
Washington	14,556	3,473	21.7%	25	10,420	40	7.9%	43
Wayne	99,282	19,639	17.9%	48	9,852	52	7.9%	45
Wilson	65,301	14,376	20.0%	34	11,725	15	10.7%	14

SOURCES: 1985 POPULATION, ALL PERSONS--estimated total resident population (including military and institutional population) as of July, 1985. Projection estimate made by N.C. Office of State Budget and Management, May 1985.

1985 POPULATION BELOW POVERTY--estimated population with incomes below Federal poverty guidelines for 1985. The statewide poverty total was estimated based on March, 1985 Current Population Survey (CPS) data for North Carolina. County estimates were obtained by multiplying total 1985 population by age-specific poverty rates reported by county in the 1980 Census (these rates were adjusted up or down to reflect statewide trends in the poverty rate for each age group between 1980-1985. The figures do not reflect changes in the age mix of the general population, however). The total for each county has been multiplied by a standard ratio so that the statewide total of persons below poverty matches the CPS estimate.

1980 POVERTY RATE--rate shown is based on excluding inmates of institutions, persons in military group quarters and in college dormitories and unrelated individuals under age 15. Figures reported in **1980 Census, General Social and Economic Characteristics, North Carolina, Vol. 1**, Table 181 (Washington, D.C.: U.S. Bureau of Census).

1985 PER CAPITA INCOME--1985 statewide average obtained from unpublished figures obtained from N.C. Office of State Management and Budget (DRI Spring, 1986 forecast). County estimates were obtained by multiplying actual 1980 per capita income by a standard ratio (ratio equals 1985 DRI statewide estimate divided by 1980 statewide per capita income). 1980 figures are computed by the U.S. Bureau of Economic Analysis and were reported in **North Carolina State Data Center Newsletter**, August, 1985.

1984 UNEMPLOYMENT RATE--average annual rate of unemployment for civilian labor force during calendar 1984. Unpublished data obtained from N.C. Employment Security Commission.

Table 2

EMPLOYMENT STATUS OF PERSONS AGE 16 AND OLDER

COUNTY	1984 ESTIMATED PERSONS AGE 16 & OVER	DISTRIBUTION BY EMPLOYMENT STATUS Employed	Unemployed	Not in Labor Force	RANK
STATE TOTAL	4,730,174	59.8%	4.3%	35.9%	
HSA I	844,088	57.1%	4.6%	38.4%	
Alexander	19,716	66.2%	4.2%	29.6%	97
Allegheny	7,003	52.5%	5.9%	41.6%	38
Ashe	17,787	51.8%	5.6%	42.6%	34
Avery	12,624	53.6%	5.1%	41.3%	41
Buncombe	136,311	56.9%	4.1%	39.0%	53
Burke	59,510	63.4%	4.0%	32.6%	84
Caldwell	50,206	63.4%	4.6%	32.0%	87
Catawba	81,274	68.2%	4.0%	27.8%	99
Cherokee	14,382	46.0%	7.4%	46.6%	10
Clay	5,020	45.4%	5.0%	49.6%	2
Cleveland	60,258	60.0%	5.9%	34.1%	80
Graham	6,022	45.8%	10.0%	44.2%	27
Haywood	36,096	48.6%	5.7%	45.7%	16
Henderson	54,281	51.6%	3.3%	45.1%	21
Jackson	27,276	48.5%	5.1%	46.4%	13
Macon	19,471	47.6%	3.4%	49.0%	3
Madison	16,556	47.5%	3.9%	48.6%	4
McDowell	30,613	57.6%	6.0%	36.4%	70
Mitchell	12,658	51.3%	5.5%	43.2%	31
Polk	10,661	51.0%	3.5%	45.5%	18
Rutherford	46,393	56.4%	5.7%	37.9%	59
Swain	9,908	45.5%	8.6%	45.9%	15
Transylvania	19,326	53.7%	2.7%	43.6%	29
Watauga	31,548	52.0%	2.9%	45.1%	19
Wilkes	47,682	62.5%	3.5%	34.0%	81
Yancey	11,506	49.7%	5.4%	44.9%	23
HSA II	900,521	62.3%	4.2%	33.5%	
Alamance	78,092	62.8%	4.8%	32.4%	86
Caswell	13,217	55.0%	5.0%	40.0%	47
Davidson	90,724	64.8%	4.3%	30.9%	93
Davie	21,308	60.4%	3.8%	35.8%	72
Forsyth	206,129	61.6%	3.5%	34.9%	76
Guilford	256,261	63.7%	3.7%	32.6%	83
Randolph	71,475	67.2%	4.0%	28.8%	98
Rockingham	62,859	58.6%	6.1%	35.3%	74
Stokes	29,525	58.3%	4.8%	36.9%	65
Surry	45,773	57.9%	5.5%	36.6%	67
Yadkin	25,159	58.3%	4.5%	37.2%	61
HSA III	811,080	64.8%	3.9%	31.3%	
Cabarrus	72,853	63.6%	5.1%	31.3%	91
Gaston	133,415	65.0%	4.4%	30.6%	94
Iredell	61,630	63.2%	4.3%	32.5%	85
Lincoln	35,321	63.7%	4.9%	31.4%	90
Mecklenburg	326,785	67.0%	3.3%	29.7%	96
Rowan	85,576	60.6%	3.6%	35.8%	73
Stanly	35,559	61.5%	4.7%	33.8%	82
Union	59,941	64.3%	3.7%	32.0%	88
HSA IV	746,898	62.0%	3.1%	34.9%	
Chatham	22,930	66.1%	4.2%	29.7%	95
Durham	144,939	62.8%	2.4%	34.8%	77
Franklin	32,958	55.3%	4.2%	40.5%	43
Granville	33,252	53.5%	4.0%	42.5%	35
Johnston	54,132	59.6%	3.8%	36.6%	68
Lee	30,275	59.7%	5.8%	34.5%	78
Orange	77,005	59.9%	2.2%	37.9%	58
Person	23,129	56.1%	5.9%	38.0%	56
Vance	31,494	52.6%	6.3%	41.1%	42
Wake	284,862	66.4%	2.3%	31.3%	92
Warren	11,922	48.3%	5.3%	46.4%	12

COUNTY	1984 ESTIMATED PERSONS AGE 16 & OVER	DISTRIBUTION BY EMPLOYMENT STATUS Employed	Unemployed	Not in Labor Force	RANK
HSA V	640,362	55.7%	5.6%	38.7%	
Anson	20,858	57.0%	4.8%	38.2%	55
Bladen	24,873	47.9%	7.1%	45.0%	22
Brunswick	38,530	48.8%	6.3%	44.9%	24
Columbus	42,850	50.1%	6.4%	43.5%	30
Cumberland	111,909	62.9%	5.2%	31.9%	89
Harnett	43,740	55.6%	4.3%	40.1%	46
Hoke	12,576	55.4%	6.7%	37.9%	57
Montgomery	17,896	61.6%	4.0%	34.4%	79
Moore	43,561	55.8%	4.3%	39.9%	48
New Hanover	88,746	56.7%	5.5%	37.8%	60
Pender	16,963	50.5%	6.8%	42.7%	33
Richmond	31,030	54.0%	6.2%	39.8%	49
Robeson	80,804	52.9%	6.8%	40.3%	45
Sampson	41,201	55.3%	5.5%	39.2%	51
Scotland	24,826	57.8%	5.6%	36.6%	69
HSA VI	787,224	55.8%	4.9%	39.3%	
Beaufort	35,959	53.8%	4.6%	41.6%	39
Bertie	17,689	48.6%	5.5%	45.9%	14
Camden	4,981	49.6%	3.0%	47.4%	7
Carteret	34,238	53.3%	3.8%	42.9%	32
Chowan	9,526	51.8%	3.1%	45.1%	20
Craven	48,891	61.1%	3.8%	35.1%	75
Currituck	8,712	49.9%	2.9%	47.2%	8
Dare	17,048	54.4%	4.2%	41.4%	40
Duplin	29,347	53.5%	6.2%	40.3%	44
Edgecombe	48,625	57.9%	6.1%	36.0%	71
Gates	6,348	51.0%	2.4%	46.6%	11
Greene	14,029	58.3%	4.5%	37.2%	62
Halifax	43,235	48.1%	6.3%	45.6%	17
Hertford	21,012	51.2%	5.1%	43.7%	28
Hyde	5,162	48.6%	6.8%	44.6%	25
Jones	7,180	53.9%	3.9%	42.2%	36
Lenoir	49,935	55.7%	5.7%	38.6%	54
Martin	19,337	54.4%	5.9%	39.7%	50
Nash	57,933	58.2%	4.7%	37.1%	63
Northampton	15,380	44.5%	5.5%	50.0%	1
Onslow	40,950	70.0%	3.7%	26.3%	100
Pamlico	8,798	48.0%	3.6%	48.4%	5
Pasquotank	21,945	54.7%	3.4%	41.9%	37
Perquimans	5,413	48.8%	3.3%	47.9%	6
Pitt	82,049	57.4%	3.6%	39.0%	52
Tyrrell	2,744	44.1%	9.1%	46.8%	9
Washington	11,606	51.0%	4.4%	44.6%	26
Wayne	63,081	58.3%	5.0%	36.7%	66
Wilson	56,070	56.3%	6.8%	36.9%	64

SOURCE: 1984 ESTIMATED PERSONS AGE 16 AND OVER--figure obtained by dividing the labor force participation rate for persons age 16 and over (1980 Census) into the 1984 civilian labor force. Figures on 1984 civilian labor force and 1984 employed persons are unpublished figures obtained from N.C. Employment Security Commission.

EMPLOYED--includes the annual average number of civilians who worked for pay or worked at least 15 hours or more as unpaid workers in a family enterprise, including persons temporarily away from work due to non-economic reasons (illness, bad weather, labor disputes).

UNEMPLOYED--includes the average annual number of civilians who were unemployed. The unemployed include only those without jobs who make a specific effort to find jobs and are available for employment during a given week. Persons on layoff from a job or waiting to report to a new job within 30 days also are included as unemployed. The percent shown does not match the unemployment rate shown in Table 1 because the unemployment rate is the percent of those in the labor force who are unemployed (i.e., it excludes all persons who are without jobs and are not seeking employment). In contrast, the percent shown is the fraction of all persons 16 and older who are unemployed (including those not in the labor force).

NOT IN LABOR FORCE--includes the average annual number of persons who are not working or or looking for work (e.g., students, homemakers and those with disabilities that prevent working). Counties with the highest fraction of adults not in the labor force are ranked the highest.

Table 3

DISTRIBUTION OF EMPLOYMENT BY TYPE AND SIZE OF EMPLOYER

COUNTY	1984 CIVILIAN EMPLOY-MENT	DISTRIBUTION OF EMPLOYED PERSONS, BY TYPE OF EMPLOYER: Private Wage & Salary	Federal Govern-ment	State Govern-ment	Local Govern-ment	Self-Employed	Unpaid Family Workers	DISTRIBUTION OF PRIVATE EMPLOYEES, BY FIRM SIZE: Be-low 20	20 to 249	250 to 999	1000 and over	LACK OF GROUP HEALTH BENEFITS INDEX	RANK
STATE TOTAL	2,827,890	76.4%	2.7%	7.0%	6.7%	6.7%	0.5%	25%	40%	21%	13%	100	
HSA I	481,570	77.9%	2.0%	6.4%	5.9%	7.3%	0.5%	24%	39%	26%	11%	99	
Alexander	13,060	82.4%	0.8%	3.8%	3.8%	8.4%	0.9%	21%	38%	40%	0%	97	75
Allegheny	3,680	73.5%	1.9%	4.6%	5.4%	14.1%	0.7%	29%	13%	57%	0%	99	67
Ashe	9,220	73.9%	1.3%	6.7%	4.9%	12.6%	0.6%	26%	30%	44%	0%	101	58
Avery	6,770	70.2%	1.9%	7.8%	5.0%	13.3%	1.6%	34%	48%	19%	0%	110	25
Buncombe	77,620	77.6%	4.0%	5.1%	6.5%	6.3%	0.5%	27%	44%	19%	11%	98	70
Burke	37,750	77.0%	1.2%	12.2%	4.5%	4.8%	0.3%	15%	31%	37%	16%	88	100
Caldwell	31,830	84.1%	1.1%	4.5%	5.2%	5.0%	0.2%	17%	37%	28%	18%	95	87
Catawba	55,390	85.8%	1.0%	3.2%	5.0%	4.7%	0.3%	20%	51%	29%	0%	97	79
Cherokee	6,620	72.8%	3.7%	6.1%	6.6%	10.3%	0.5%	25%	41%	34%	0%	107	38
Clay	2,280	68.7%	2.2%	8.7%	6.5%	13.0%	1.0%	55%	45%	0%	0%	115	11
Cleveland	36,160	82.2%	0.9%	4.2%	6.7%	5.6%	0.4%	24%	42%	25%	8%	102	55
Graham	2,760	68.5%	7.3%	7.0%	5.5%	11.0%	0.6%	45%	22%	33%	0%	116	9
Haywood	17,540	74.8%	2.3%	6.3%	8.4%	7.8%	0.5%	30%	29%	3%	37%	108	30
Henderson	28,010	77.5%	1.3%	4.5%	6.2%	9.8%	0.8%	30%	37%	20%	13%	97	72
Jackson	13,240	56.2%	4.8%	21.9%	7.7%	8.8%	0.6%	41%	37%	22%	0%	106	41
Macon	9,260	67.6%	3.4%	6.3%	7.5%	13.6%	1.6%	48%	52%	0%	0%	107	37
Madison	7,870	65.7%	2.4%	6.3%	10.1%	14.3%	1.1%	32%	47%	20%	0%	104	48
McDowell	17,620	81.3%	1.2%	6.3%	4.6%	6.2%	0.4%	17%	20%	46%	17%	93	93
Mitchell	6,500	74.6%	2.3%	6.8%	7.0%	9.0%	0.3%	29%	32%	40%	0%	100	62
Polk	5,440	74.7%	1.6%	2.8%	7.5%	13.0%	0.5%	40%	46%	14%	0%	100	63
Rutherford	26,170	82.0%	0.7%	5.2%	5.0%	6.5%	0.5%	21%	26%	41%	12%	94	90
Swain	4,510	64.7%	10.7%	5.2%	9.8%	8.8%	0.8%	44%	56%	0%	0%	115	10
Transylvania	10,370	77.9%	3.8%	3.9%	6.8%	7.1%	0.6%	21%	20%	8%	51%	94	89
Watauga	16,400	58.0%	1.3%	23.2%	6.4%	10.5%	0.7%	40%	39%	21%	0%	107	35
Wilkes	29,780	79.7%	1.1%	4.9%	5.1%	8.5%	0.7%	18%	32%	18%	32%	93	94
Yancey	5,720	71.6%	2.0%	8.2%	5.6%	12.3%	0.2%	36%	29%	35%	0%	106	44
HSA II	561,440	81.6%	1.6%	4.4%	5.9%	6.1%	0.4%	22%	40%	20%	18%	98	
Alamance	49,010	82.2%	1.2%	4.7%	5.5%	6.0%	0.3%	23%	46%	30%	0%	98	69
Caswell	7,270	74.4%	2.9%	6.4%	5.4%	9.6%	1.3%	51%	49%	0%	0%	122	2
Davidson	58,810	83.2%	1.0%	3.1%	5.7%	6.6%	0.4%	21%	34%	26%	19%	96	84
Davie	12,860	81.4%	1.9%	3.6%	4.5%	8.0%	0.5%	25%	42%	33%	0%	103	50
Forsyth	126,900	83.1%	1.7%	3.7%	6.6%	4.6%	0.2%	20%	37%	18%	25%	97	78
Guilford	163,360	80.3%	2.3%	5.6%	6.5%	5.0%	0.3%	23%	47%	13%	17%	98	71
Randolph	48,020	83.5%	1.0%	3.3%	4.4%	7.2%	0.5%	21%	35%	30%	14%	93	95
Rockingham	36,830	82.1%	1.2%	4.0%	5.8%	6.5%	0.3%	19%	23%	35%	23%	94	88
Stokes	17,200	78.6%	0.9%	3.9%	6.5%	9.2%	0.9%	43%	45%	12%	0%	116	8
Surry	26,500	79.7%	0.9%	4.4%	4.7%	9.7%	0.7%	18%	32%	23%	26%	97	77
Yadkin	14,680	77.8%	1.1%	3.8%	4.9%	11.8%	0.7%	44%	37%	20%	0%	111	18
HSA III	525,780	82.9%	1.7%	3.7%	6.4%	5.0%	0.4%	23%	42%	22%	13%	97	
Cabarrus	46,340	83.7%	1.5%	4.2%	5.2%	5.1%	0.4%	24%	35%	18%	24%	94	91
Gaston	86,690	86.1%	1.1%	3.0%	5.6%	3.8%	0.4%	17%	31%	24%	27%	90	97
Iredell	38,950	82.1%	1.1%	4.0%	5.6%	6.6%	0.6%	23%	44%	33%	0%	97	74
Lincoln	22,500	82.0%	0.9%	3.5%	6.2%	6.9%	0.4%	25%	41%	34%	0%	101	59
Mecklenburg	219,050	82.5%	1.9%	3.5%	7.4%	4.4%	0.3%	24%	46%	19%	11%	99	66
Rowan	51,830	81.5%	3.3%	4.1%	5.2%	5.5%	0.4%	25%	40%	20%	16%	95	86
Stanly	21,870	81.1%	1.3%	5.2%	5.5%	6.4%	0.5%	23%	32%	31%	14%	93	96
Union	38,550	81.2%	1.3%	3.2%	6.5%	7.3%	0.5%	23%	43%	34%	0%	99	65
HSA IV	463,280	69.7%	2.9%	14.2%	6.6%	6.1%	0.5%	26%	40%	18%	15%	95	
Chatham	15,160	69.9%	2.3%	12.6%	6.5%	8.2%	0.5%	23%	39%	37%	0%	88	98
Durham	91,080	73.8%	4.5%	9.1%	8.2%	4.1%	0.3%	20%	35%	14%	32%	88	99
Franklin	18,220	71.0%	1.8%	9.3%	7.7%	9.2%	1.0%	30%	42%	27%	0%	100	64
Granville	17,800	61.9%	3.1%	18.8%	6.5%	8.0%	1.7%	23%	43%	34%	0%	97	73
Johnston	32,270	70.4%	1.3%	8.9%	6.4%	11.7%	1.3%	38%	40%	23%	0%	105	47
Lee	18,080	78.5%	2.2%	5.6%	6.6%	6.6%	0.5%	27%	45%	28%	0%	106	42
Orange	46,130	53.8%	2.9%	31.3%	5.9%	5.8%	0.3%	35%	43%	10%	12%	96	83
Person	12,970	76.0%	1.6%	7.3%	6.1%	8.5%	0.4%	23%	30%	18%	28%	100	61
Vance	16,580	76.3%	1.8%	7.8%	6.4%	7.1%	0.5%	21%	32%	18%	29%	102	54
Wake	189,230	70.0%	2.9%	15.9%	5.9%	4.9%	0.3%	27%	44%	17%	11%	95	85
Warren	5,760	68.4%	2.7%	10.4%	9.5%	7.9%	1.1%	50%	31%	19%	0%	108	31

COUNTY	1984 CIVILIAN EMPLOY-MENT	DISTRIBUTION OF EMPLOYED PERSONS, BY TYPE OF EMPLOYER: Private Wage & Salary	Federal Govern-ment	State Govern-ment	Local Govern-ment	Self-Employed	Unpaid Family Workers	DISTRIBUTION OF PRIVATE EMPLOYEES, BY FIRM SIZE: Be-low 20	20 to 249	250 to 999	1000 and over	LACK OF GROUP HEALTH BENEFITS INDEX	RANK
HSA V	356,650	72.2%	4.2%	6.9%	8.1%	7.8%	0.7%	29%	38%	21%	12%	107	
Anson	11,880	76.9%	1.8%	5.4%	8.4%	7.3%	0.3%	25%	40%	35%	0%	96	81
Bladen	11,910	72.1%	2.3%	6.7%	8.4%	9.3%	1.2%	35%	30%	35%	0%	114	14
Brunswick**	18,810	69.1%	2.7%	6.2%	8.8%	12.3%	1.0%	34%	34%	0%	32%	114	15
Columbus	21,450	70.7%	2.6%	7.6%	6.9%	10.5%	1.7%	28%	25%	29%	17%	108	29
Cumberland	70,390	66.3%	10.1%	7.3%	10.2%	5.8%	0.3%	34%	46%	11%	9%	110	23
Harnett***	24,340	72.0%	4.1%	6.3%	6.6%	10.1%	0.8%	28%	36%	20%	16%	105	46
Hoke	6,970	73.0%	3.0%	7.1%	9.6%	6.6%	0.7%	18%	9%	28%	45%	99	68
Montgomery	11,030	78.9%	1.7%	6.0%	5.0%	7.6%	0.8%	18%	46%	36%	0%	94	92
Moore	24,320	74.3%	1.9%	7.0%	6.6%	9.3%	0.9%	27%	36%	24%	12%	96	80
New Hanover	50,340	75.2%	2.7%	7.0%	8.1%	6.6%	0.4%	30%	40%	15%	16%	106	40
Pender	8,560	70.1%	4.4%	8.1%	7.4%	8.8%	1.2%	51%	49%	0%	0%	119	4
Richmond	16,770	79.6%	1.4%	6.2%	7.2%	4.6%	0.8%	29%	39%	32%	0%	107	36
Robeson	42,760	73.6%	2.9%	6.7%	8.1%	7.9%	0.8%	27%	38%	26%	9%	110	26
Sampson	22,780	69.6%	2.2%	7.3%	7.3%	12.7%	0.9%	32%	39%	29%	0%	104	49
Scotland	14,340	78.9%	2.0%	7.2%	7.3%	4.3%	0.4%	17%	28%	38%	17%	96	82
HSA VI	439,170	69.3%	4.5%	8.6%	8.0%	8.7%	0.9%	33%	41%	18%	8%	106	
Beaufort	19,340	71.9%	2.6%	6.7%	6.8%	10.8%	1.1%	23%	28%	19%	30%	97	76
Bertie	8,590	70.4%	2.2%	6.4%	8.1%	10.8%	2.0%	23%	21%	14%	42%	100	60
Camden	2,470	65.9%	8.0%	6.9%	8.8%	9.1%	1.3%	89%	11%	0%	0%	124	1
Carteret	18,240	59.2%	12.5%	8.7%	6.6%	12.3%	0.7%	48%	41%	11%	0%	110	24
Chowan	4,930	69.3%	4.4%	8.7%	7.3%	9.8%	0.6%	37%	63%	0%	0%	109	27
Craven	29,880	65.3%	11.2%	6.7%	9.0%	7.0%	0.7%	39%	49%	13%	0%	106	43
Currituck	4,350	61.6%	11.2%	7.2%	9.3%	9.9%	0.8%	63%	37%	0%	0%	115	12
Dare	9,270	62.2%	3.6%	5.9%	8.9%	18.3%	1.0%	67%	33%	0%	0%	117	6
Duplin	15,690	67.8%	3.2%	6.2%	8.0%	13.6%	1.2%	39%	38%	23%	0%	111	21
Edgecombe	28,130	79.7%	2.0%	4.8%	7.1%	6.0%	0.5%	24%	43%	33%	0%	103	51
Gates	3,240	66.8%	4.2%	11.3%	8.6%	8.2%	0.7%	57%	43%	0%	0%	110	22
Greene	8,180	65.8%	2.1%	8.9%	8.6%	12.6%	1.9%	47%	53%	0%	0%	115	13
Halifax	20,790	72.8%	2.0%	7.7%	8.5%	8.1%	0.9%	33%	39%	28%	0%	111	17
Hertford	10,750	71.2%	3.3%	7.4%	8.0%	9.0%	1.0%	32%	45%	22%	0%	108	34
Hyde	2,510	50.4%	5.6%	12.3%	9.5%	20.2%	2.0%	59%	41%	0%	0%	106	39
Jones	3,870	61.6%	5.2%	8.0%	9.1%	13.5%	2.6%	60%	40%	0%	0%	114	16
Lenoir	27,820	70.9%	2.0%	12.1%	7.2%	7.1%	0.7%	27%	38%	24%	11%	103	53
Martin	10,510	68.6%	2.7%	6.5%	9.8%	11.6%	0.8%	40%	47%	13%	0%	111	19
Nash	33,690	77.3%	1.8%	6.0%	6.8%	7.2%	1.0%	24%	42%	26%	8%	101	57
Northampton	6,840	74.0%	2.5%	8.8%	6.0%	8.3%	0.4%	38%	49%	12%	0%	117	5
Onslow	28,650	63.0%	14.7%	4.8%	8.3%	8.2%	1.0%	44%	47%	9%	0%	109	28
Pamlico	4,220	63.7%	8.2%	7.7%	7.4%	11.6%	1.4%	42%	58%	0%	0%	111	20
Pasquotank	12,000	63.7%	7.1%	10.4%	9.8%	8.2%	0.8%	46%	54%	0%	0%	108	33
Perquimans	2,640	64.7%	5.1%	8.6%	7.4%	13.8%	0.4%	75%	25%	0%	0%	116	7
Pitt	47,060	67.3%	2.1%	14.6%	8.7%	6.9%	0.5%	34%	44%	12%	9%	106	45
Tyrrell	1,210	62.4%	1.7%	13.6%	7.6%	12.6%	2.2%	66%	34%	0%	0%	119	3
Washington	5,920	72.7%	2.5%	8.8%	7.8%	7.4%	0.7%	21%	25%	7%	46%	102	56
Wayne	36,790	68.6%	3.1%	11.8%	7.8%	8.0%	0.6%	34%	45%	22%	0%	108	32
Wilson	31,590	73.2%	1.7%	8.1%	9.3%	6.9%	0.8%	24%	40%	19%	18%	103	52

SOURCE: 1984 CIVILIAN EMPLOYMENT--includes the average annual number of civilian employees, including federal (non-military), state and local employees. Unpublished data obtained from N.C. Employment Security Commission.

DISTRIBUTION OF EMPLOYED PERSONS, BY TYPE OF EMPLOYER--percentages shown are based on 1980 Census data, since these are the most recent available estimates by county for all of the categories shown.

DISTRIBUTION OF PRIVATE EMPLOYEES, BY FIRM SIZE--excludes government employees, railroad employees and self-employed persons. Note that the percentages shown are based on size of establishment, which is any single physical location where services or industrial operations are performed. Hence a single employer may actually have employees in more than 1 establishment. The percentages were derived as follows. The total number of establishments, by size is reported by county. For each size category, the number of establishments was multiplied by the average number of employees in establishments for that size category (computed based on state total data showing both number of establishments and number of employees within each size category). The resultant number of employees was summed across all establishments and percentages computed based on this total. Data are for establishments in operation as of mid-March, 1983, reported in **County Business Patterns, 1983: North Carolina** (Washington, D.C.: U.S. Bureau of the Census, September 1985).

LACK OF GROUP HEALTH BENEFITS INDEX--This index is intended to highlight counties where the labor force and employer size characteristics make it likely that lack of group health benefits among county residents is likely to be more common compared to the statewide average. A score of 100 equals the statewide average and

(over)

high scores indicate relatively higher rates of being uninsured. In North Carolina, 8.3 percent of full-time employees are without insurance. Compared to the average full-time employee (who has an 8.3 percent chance of being uninsured in North Carolina), it was assumed (based on North Carolina data) that the likelihood of being uninsured was 3.7 times as high among the unemployed, 3 times as high among non-elderly adults not in the labor force and 73 percent lower among the elderly. Based on national data, it was assumed that the rate of being uninsured was 1.5 times higher among the self-employed or unpaid family workers, 2.5 times higher among employees in firms with under 20 employees, 1.4 times as high among employees in firms with 20 to 249 employees, 39 percent lower in firms of 250-999 employees and 41 percent lower in firms with 1000 or more employees. These rates of being uninsured were multiplied by the estimated share of the population in each of the categories described to yield a weighted average for each county. This average was divided by an equivalently derived state average and multiplied by 100 to yield the index shown.

NUMBER AND CHARACTERISTICS OF MEDICALLY INDIGENT

Size of Medically Indigent Population

Age Distribution of Medically Indigent

Number of Medicaid and Medicare Eligibles by Category

Table 4

SIZE OF MEDICALLY INDIGENT POPULATION

COUNTY	1985 ESTIMATED UNINSURED POOR Average Daily Persons	Per 1000 Poor	RANK	1985 MEDICAID ENROLLED Annual Persons	Per 1000 Poor	RANK	PERCENT CHANGE IN ENROLLED 1985/81	RANK	1984 DAILY MEDICARE ENROLLED
STATE TOTAL	402,092	398		414,353	411		-9.8%		752,139
HSA I	64,610	399		52,541	324		-7.5%		154,896
Alexander	591	231	98	752	295	79	-34.0%	1	2,739
Allegheny	1,169	545	20	521	243	92	-17.0%	14	1,747
Ashe	3,220	551	18	1,479	253	89	0.7%	85	3,716
Avery	1,656	557	12	821	276	83	-7.5%	57	2,256
Buncombe	8,393	356	68	6,794	288	81	-10.7%	38	26,307
Burke	2,395	288	88	3,068	368	60	-12.7%	27	9,191
Caldwell	2,232	288	87	3,035	391	52	12.4%	98	7,934
Catawba	3,416	339	79	4,439	440	30	-11.7%	32	13,465
Cherokee	2,720	557	14	1,151	236	93	4.0%	88	3,519
Clay	763	431	50	465	262	86	6.4%	92	1,370
Cleveland	4,244	348	73	6,270	514	11	-17.7%	11	11,604
Graham	835	553	17	532	352	66	-10.1%	47	1,196
Haywood	4,249	525	37	2,763	341	68	5.8%	90	7,738
Henderson	3,823	431	51	2,444	275	84	-5.4%	68	12,779
Jackson	3,006	517	38	1,413	243	91	13.0%	99	3,404
Macon	1,852	424	53	778	178	99	12.1%	97	4,730
Madison	1,881	393	61	1,691	353	65	-7.9%	54	2,850
McDowell	1,106	234	95	1,956	414	40	-4.6%	72	5,157
Mitchell	1,433	548	19	947	362	64	-18.8%	9	2,612
Polk	969	439	46	450	204	95	-16.7%	17	3,165
Rutherford	4,501	529	35	3,495	411	46	-8.8%	52	8,661
Swain	1,721	557	13	1,000	324	72	5.2%	89	1,913
Transylvania	829	234	94	1,089	308	77	-15.4%	21	3,706
Watauga	1,945	227	99	1,219	142	100	-10.6%	39	3,368
Wilkes	3,454	379	63	2,937	322	73	6.9%	93	7,290
Yancey	2,206	556	15	1,032	260	87	-10.3%	44	2,479
HSA II	44,973	308		61,535	421		-14.7%		146,243
Alamance	4,161	358	67	4,695	404	48	-5.9%	67	15,365
Caswell	2,658	562	9	1,877	397	50	-16.0%	19	2,285
Davidson	4,674	342	77	5,218	381	55	-11.1%	36	13,028
Davie	781	237	91	918	279	82	-23.5%	6	3,245
Forsyth	6,386	195	100	16,466	503	14	-12.0%	29	31,160
Guilford	13,590	341	78	18,720	469	19	-23.2%	7	40,199
Randolph	3,197	338	81	2,496	264	85	-11.7%	34	11,531
Rockingham	3,889	321	84	5,462	450	23	-4.5%	74	12,244
Stokes	1,153	236	93	1,424	292	80	-10.5%	41	3,305
Surry	3,408	377	64	3,087	342	67	-5.3%	69	9,635
Yadkin	1,076	234	96	1,172	255	88	-17.6%	13	4,246
HSA III	42,682	352		60,087	495		-8.9%		123,852
Cabarrus	3,046	321	83	4,060	428	36	-10.2%	45	13,854
Gaston	6,707	343	76	11,086	567	3	-5.9%	66	20,942
Iredell	2,767	289	86	4,466	466	20	-9.1%	50	11,573
Lincoln	1,802	381	62	2,097	443	28	-1.3%	80	5,183
Mecklenburg	19,625	373	66	27,729	528	7	-10.3%	42	43,468
Rowan	3,721	339	80	4,370	398	49	-7.6%	56	14,366
Stanly	2,152	377	65	2,111	370	59	-16.9%	16	7,423
Union	2,862	325	82	4,168	473	18	-5.8%	65	7,043
HSA IV	47,952	360		51,978	390		-15.7%		96,606
Chatham	819	234	97	1,590	454	22	-14.0%	24	4,167
Durham	7,386	298	85	10,670	430	35	-23.5%	5	18,992
Franklin	3,973	562	10	2,930	414	41	-11.0%	37	4,070
Granville	3,682	527	36	2,279	326	71	-9.5%	48	4,929
Johnston	5,048	345	75	5,333	364	61	-8.6%	53	9,752
Lee	3,137	531	32	2,864	485	16	-0.6%	81	5,205
Orange	3,794	284	89	2,416	181	97	-16.2%	18	6,514
Person	2,970	536	25	2,481	448	25	-14.1%	22	4,013
Vance	4,777	540	22	4,490	508	12	-12.7%	28	5,446
Wake	9,267	250	90	14,526	392	51	-17.0%	15	30,934
Warren	3,099	570	3	2,399	441	29	-17.6%	12	2,584

COUNTY	1985 ESTIMATED UNINSURED POOR Average Daily Persons	Per 1000 Poor	RANK	1985 MEDICAID ENROLLED Annual Persons	Per 1000 Poor	RANK	PERCENT CHANGE IN ENROLLED 1985/81	RANK	1984 DAILY MEDICARE ENROLLED
HSA V	92,389	467	.	88,092	446		-6.2%		100,903
Anson	2,501	535	28	2,487	532	6	0.2%	84	3,665
Bladen	4,901	565	7	3,668	423	38	-10.1%	46	3,779
Brunswick	5,124	531	33	3,181	330	70	5.9%	91	5,370
Columbus	6,645	439	45	6,715	444	27	9.4%	96	7,130
Cumberland	22,990	468	39	20,287	413	44	-11.9%	30	15,028
Harnett	5,912	440	43	5,738	427	37	-6.3%	63	6,942
Hoke	3,056	574	1	2,535	476	17	-2.2%	78	1,541
Montgomery	877	237	92	1,609	435	34	-10.5%	40	3,092
Moore	3,599	440	44	2,509	306	78	-27.3%	4	9,367
New Hanover	6,561	351	71	8,674	463	21	-7.4%	58	13,413
Pender	3,194	566	4	2,333	414	43	0.2%	83	3,280
Richmond	4,021	532	30	3,327	440	31	-3.6%	76	6,388
Robeson	13,242	448	41	15,569	527	8	-4.2%	75	11,810
Sampson	6,276	532	31	4,481	380	56	-4.9%	71	6,438
Scotland	3,488	537	24	4,979	767	1	-2.3%	77	3,660
HSA VI	109,487	440	.	100,120	402		-8.0%		129,251
Beaufort	5,311	533	29	3,093	310	75	-6.6%	62	6,235
Bertie	2,831	405	56	2,725	390	53	-0.1%	82	3,306
Camden	576	553	16	377	362	63	-32.7%	2	776
Carteret	3,190	434	49	1,856	253	90	-32.5%	3	5,560
Chowan	1,923	562	8	1,061	310	76	-14.1%	23	2,182
Craven	5,531	350	72	5,221	330	69	-13.8%	25	7,543
Currituck	1,190	436	47	492	180	98	-19.1%	8	1,675
Dare	862	426	52	442	218	94	-7.7%	55	2,062
Duplin	4,562	435	48	3,899	372	58	-11.4%	35	5,496
Edgecombe	5,316	409	54	8,051	619	2	-7.4%	59	8,459
Gates	801	401	57	751	376	57	-13.7%	26	1,459
Greene	2,690	573	2	1,923	410	47	-11.7%	33	1,573
Halifax	8,126	444	42	9,951	544	5	-10.3%	43	8,586
Hertford	3,437	536	26	2,798	436	33	-5.0%	70	3,371
Hyde	1,058	566	5	595	318	74	-4.5%	73	989
Jones	934	399	59	1,142	488	15	-18.3%	10	1,325
Lenoir	7,190	536	27	5,958	444	26	-6.1%	64	8,504
Martin	3,801	540	23	2,551	362	62	7.3%	94	3,757
Nash	5,439	351	70	6,379	411	45	-15.8%	20	7,790
Northampton	2,797	406	55	3,880	564	4	-8.8%	51	3,526
Onslow	10,689	461	40	4,320	186	96	-7.0%	60	5,581
Pamlico	970	400	58	1,006	415	39	-1.8%	79	1,494
Pasquotank	2,968	530	34	2,464	440	32	9.0%	95	4,124
Perquimans	1,483	558	11	1,099	414	42	25.7%	100	1,695
Pitt	8,695	347	74	9,599	383	54	-9.2%	49	10,575
Tyrrell	452	394	60	595	519	9	-11.9%	31	688
Washington	1,963	565	6	1,787	515	10	3.5%	87	1,914
Wayne	6,918	352	69	8,816	449	24	-6.6%	61	10,963
Wilson	7,786	542	21	7,289	507	13	1.5%	86	8,043

SOURCES: 1985 UNINSURED POOR--includes all persons below poverty who have no private or public health insurance coverage (including Medicare or Medicaid). The county figures are estimated based on the fraction of poor adults without insurance reported in Blakely, et al., **Geographic Distribution of the Medically Indigent Uninsured Poor and of Inpatient Care Patterns in North Carolina** (Chapel Hill: University of North Carolina, March 1986). The methodology for computing these figures is described in Table 5. **CAUTION: there is a great deal of uncertainty in these county estimates, particularly for smaller counties.**

UNINSURED POOR PER 1000 POOR--equals average daily uninsured poor divided by total number of people below poverty times 1000. This ratio indicates the fraction of the poverty population which is without insurance on an average day (e.g., statewide 400 out of every 1,000 poor--or 40%--are uninsured). Counties with the greatest ratios are ranked the highest.

1985 MEDICAID ENROLLED--includes all persons who were enrolled in Medicaid at any time during state fiscal year 1985, regardless of whether they received any medical services through Medicaid (see Table 6 for detailed breakdown of eligibles by category). Note that additional individuals in a county may be technically eligible for Medicaid but decline to participate. Also, the number of enrollees per 1,000 poor overstates the fraction of poor people who obtain Medicaid since statewide, roughly one-fourth of Medicaid eligibles have incomes above poverty. Data obtained from Division of Medical Assistance, **Medicaid in North Carolina, Annual Report 1980-1981** and unpublished FY1985 data.

PERCENT CHANGE IN ENROLLED--shows the percent change in the annual number enrolled in Medicaid during FY1985 compared to FY1981. Counties with the largest reductions in enrollees are ranked highest.

1984 DAILY MEDICARE ENROLLED--includes all persons enrolled in Medicare on July 1, 1984. See Table 3 for breakdown of eligibles by category. Statewide total includes 386 enrollees with unknown county of residence. Unpublished data obtained from Health Care Financing Administration.

Table 5

AGE DISTRIBUTION OF MEDICALLY INDIGENT

COUNTY	PERCENT OF TOTAL POPULATION UNINSURED	RANK	1985 ESTIMATED TOTAL PERSONS UNINSURED Children Under 5	Children 5-17	Adults 18-64	Elderly 65 +	Total	PERCENT UNINSURED WHO ARE BELOW POVERTY	1985 ESTIMATED TOTAL UNINSURED POOR Children Under 5	Children 5-17	Adults 18-64	Elderly 65 +
STATE TOTAL	14.0%		78,052	221,789	558,765	13,299	871,906	46.1%	48,472	134,070	211,769	7,780
HSA I	13.4%		11,416	33,866	95,430	2,986	143,697	45.0%	6,619	18,878	37,239	1,873
Alexander	10.2%	98	205	581	1,909	42	2,737	21.6%	54	147	368	22
Allegheny	18.5%	20	191	388	1,218	56	1,852	63.1%	159	258	707	46
Ashe	20.4%	18	423	1,172	3,075	137	4,806	67.0%	339	888	1,880	114
Avery	18.8%	12	254	739	1,787	57	2,837	58.4%	183	514	918	41
Buncombe	12.4%	68	1,615	4,668	14,024	446	20,753	40.4%	927	2,468	4,750	248
Burke	10.2%	88	600	1,792	5,216	123	7,730	31.0%	272	751	1,307	67
Caldwell	10.9%	87	562	1,767	5,024	113	7,466	29.9%	241	707	1,224	61
Catawba	11.0%	79	984	2,766	8,384	173	12,307	27.8%	396	1,049	1,894	77
Cherokee	20.5%	14	362	1,115	2,554	98	4,129	65.9%	277	848	1,523	73
Clay	18.1%	50	102	299	858	37	1,296	58.8%	72	205	459	27
Cleveland	12.8%	73	906	2,764	6,971	190	10,830	39.2%	476	1,451	2,204	113
Graham	19.7%	17	115	361	898	29	1,402	59.5%	72	245	498	20
Haywood	16.8%	37	615	1,956	5,250	162	7,983	53.2%	432	1,275	2,438	103
Henderson	12.8%	51	656	1,886	5,713	215	8,470	45.1%	376	1,018	2,322	106
Jackson	18.3%	38	424	1,143	3,401	92	5,060	59.4%	305	759	1,879	64
Macon	15.2%	53	229	737	2,493	121	3,579	51.7%	135	419	1,215	83
Madison	17.6%	61	249	721	1,955	79	3,004	62.6%	185	517	1,118	61
McDowell	10.2%	95	283	845	2,567	71	3,765	29.4%	109	312	648	38
Mitchell	17.1%	19	204	548	1,626	67	2,445	58.6%	151	365	867	49
Polk	13.4%	46	153	492	1,283	58	1,987	48.7%	102	316	522	29
Rutherford	14.9%	35	726	2,242	5,330	211	8,508	52.9%	464	1,455	2,431	151
Swain	22.9%	13	198	701	1,562	49	2,510	68.5%	144	556	985	36
Transylvania	10.4%	94	192	595	1,784	53	2,624	31.5%	76	240	486	26
Watauga	12.9%	99	294	813	3,329	62	4,498	43.2%	152	365	1,397	31
Wilkes	12.8%	63	566	1,911	5,194	167	7,838	44.0%	271	1,082	1,976	124
Yancey	21.1%	15	305	865	2,026	80	3,277	67.3%	250	667	1,225	64
HSA II	11.6%		9,960	31,303	91,537	2,103	134,902	33.3%	4,729	14,613	24,595	1,035
Alamance	11.8%	67	777	2,831	8,292	218	12,117	34.3%	354	1,373	2,323	110
Caswell	20.5%	9	327	1,330	2,847	67	4,572	58.1%	208	944	1,462	44
Davidson	11.6%	77	1,021	3,338	9,163	198	13,720	34.1%	474	1,627	2,473	100
Davie	11.0%	91	214	709	2,096	48	3,067	25.4%	66	259	434	23
Forsyth	10.1%	100	1,820	5,553	18,336	354	26,064	24.5%	721	2,046	3,496	123
Guilford	11.9%	78	2,980	9,143	26,250	545	38,918	34.9%	1,513	4,545	7,286	245
Randolph	10.9%	81	772	2,375	7,218	191	10,556	30.3%	324	967	1,793	112
Rockingham	11.7%	84	825	2,427	6,692	185	10,129	38.4%	465	1,227	2,093	105
Stokes	12.3%	93	309	1,044	2,948	68	4,368	26.4%	95	371	653	35
Surry	13.0%	64	673	1,797	5,201	157	7,828	43.5%	410	957	1,944	97
Yadkin	12.0%	96	241	756	2,494	72	3,562	30.2%	99	298	638	40
HSA III	11.7%		10,143	29,769	82,661	1,771	124,344	34.3%	5,140	14,341	22,375	825
Cabarrus	10.7%	83	787	2,285	6,732	173	9,977	30.5%	379	968	1,624	75
Gaston	11.0%	76	1,514	4,763	12,237	283	18,798	35.7%	751	2,395	3,422	139
Iredell	10.9%	86	696	2,232	6,333	168	9,429	29.3%	279	907	1,498	82
Lincoln	12.1%	62	439	1,284	3,626	87	5,436	33.1%	196	572	986	48
Mecklenburg	12.4%	66	4,551	13,061	36,304	593	54,509	36.0%	2,509	6,746	10,121	248
Rowan	11.0%	80	922	2,484	7,753	214	11,373	32.7%	461	1,115	2,054	92
Stanly	11.6%	65	487	1,271	3,862	130	5,749	37.4%	263	592	1,218	80
Union	11.6%	82	747	2,389	5,815	123	9,074	31.5%	303	1,046	1,451	61
HSA IV	12.8%		8,960	26,874	75,939	1,590	113,363	42.3%	4,989	15,053	27,024	885
Chatham	9.4%	97	236	678	2,355	58	3,327	24.6%	82	221	489	27
Durham	11.3%	85	1,533	4,003	12,334	252	18,123	40.7%	902	2,162	4,205	117
Franklin	19.3%	10	478	1,795	3,757	141	6,171	64.4%	341	1,377	2,146	110
Granville	17.0%	36	530	1,678	3,939	116	6,263	58.8%	386	1,154	2,060	82
Johnston	14.4%	75	884	2,676	7,020	189	10,770	46.9%	524	1,586	2,812	125
Lee	16.1%	32	619	1,639	4,018	100	6,378	49.2%	406	1,030	1,635	66
Orange	12.0%	89	633	1,583	7,473	95	9,784	38.8%	298	605	2,859	32
Person	17.0%	25	405	1,524	3,169	88	5,185	57.3%	260	1,119	1,533	58
Vance	19.4%	22	693	2,384	4,246	116	7,439	64.2%	523	1,872	2,302	80
Wake	10.5%	90	2,505	7,578	25,390	360	35,833	25.9%	876	2,762	5,496	134
Warren	25.3%	3	443	1,336	2,238	74	4,091	75.7%	392	1,165	1,487	55

COUNTY	PERCENT OF TOTAL POPULATION UNINSURED	RANK	1985 ESTIMATED TOTAL PERSONS UNINSURED Children Under 5	Children 5-17	Adults 18-64	Elderly 65 +	Total	PERCENT UNINSURED WHO ARE BELOW POVERTY	1985 ESTIMATED TOTAL UNINSURED POOR Children Under 5	Children 5-17	Adults 18-64	Elderly 65 +
HSA V	17.4%		17,531	47,299	97,838	2,129	164,797	56.1%	12,373	33,347	45,293	1,376
Anson	16.4%	28	390	1,286	2,569	109	4,354	57.4%	243	897	1,277	84
Bladen	23.2%	7	682	2,192	4,180	113	7,167	68.4%	537	1,754	2,526	85
Brunswick**	19.5%	33	877	2,377	5,244	123	8,622	59.4%	671	1,670	2,706	77
Columbus	19.7%	45	963	3,007	6,109	158	10,237	64.9%	728	2,328	3,474	115
Cumberland	17.3%	39	5,740	12,498	25,726	274	44,237	52.0%	4,011	8,501	10,316	161
Harnett***	16.8%	43	1,113	2,878	6,501	153	10,645	55.5%	782	2,034	2,996	99
Hoke	20.2%	1	616	1,526	2,436	50	4,627	66.0%	493	1,183	1,345	36
Montgomery	10.7%	92	217	605	1,683	47	2,552	34.3%	102	276	474	26
Moore	13.7%	44	622	1,885	4,803	162	7,472	48.1%	383	1,192	1,931	92
New Hanover	13.8%	71	1,238	3,882	10,190	204	15,515	42.3%	702	2,248	3,516	96
Pender	21.3%	4	476	1,540	3,032	91	5,139	62.1%	351	1,162	1,616	65
Richmond	16.8%	30	719	2,061	4,698	136	7,615	52.8%	471	1,361	2,101	89
Robeson	19.5%	41	2,347	6,930	11,365	250	20,891	63.4%	1,782	5,328	5,965	168
Sampson	19.4%	31	979	2,798	5,890	176	9,842	63.8%	747	2,100	3,303	126
Scotland	17.2%	24	554	1,834	3,410	83	5,881	59.3%	369	1,315	1,746	58
HSA VI	17.4%		20,043	52,678	115,360	2,721	190,803	57.4%	14,622	37,838	55,242	1,785
Beaufort	18.9%	29	841	2,341	4,799	166	8,147	65.2%	646	1,811	2,729	125
Bertie	19.1%	56	395	1,314	2,329	77	4,115	68.8%	318	1,057	1,398	58
Camden	18.8%	16	106	269	713	23	1,110	51.8%	73	161	327	15
Carteret	14.9%	49	611	1,609	4,846	121	7,188	44.4%	361	926	1,834	68
Chowan	21.8%	8	295	807	1,672	52	2,826	68.0%	240	645	1,002	37
Craven	14.9%	72	1,384	2,903	7,044	125	11,456	48.3%	899	1,876	2,685	71
Currituck	16.9%	47	234	561	1,445	42	2,283	52.1%	170	346	647	27
Dare	14.2%	52	154	447	1,706	42	2,349	36.7%	70	205	569	18
Duplin	18.4%	48	715	2,056	4,714	137	7,622	59.8%	515	1,458	2,490	99
Edgecombe	16.3%	54	914	2,919	5,516	130	9,479	56.1%	636	2,111	2,491	79
Gates	16.2%	57	140	402	912	31	1,485	53.9%	108	265	409	19
Greene	23.5%	2	441	1,272	2,180	44	3,937	68.3%	369	1,055	1,236	30
Halifax	21.0%	42	1,244	3,766	6,630	177	11,817	68.8%	1,051	3,075	3,882	119
Hertford	21.3%	26	514	1,562	2,941	99	5,116	67.2%	407	1,244	1,709	77
Hyde	23.9%	5	151	439	814	34	1,438	73.5%	127	371	532	27
Jones	17.2%	59	151	458	1,049	31	1,690	55.2%	96	308	508	21
Lenoir	18.9%	27	1,180	3,398	6,851	166	11,596	62.0%	905	2,585	3,587	113
Martin	21.5%	23	542	1,834	3,254	90	5,720	66.4%	427	1,473	1,836	64
Nash	14.7%	70	942	2,922	6,446	148	10,458	52.0%	635	1,997	2,722	85
Northampton	19.6%	55	408	1,344	2,530	72	4,355	64.2%	334	1,059	1,359	45
Onslow	17.1%	40	3,204	4,957	12,515	126	20,803	51.4%	2,325	3,180	5,104	79
Pamlico	16.5%	58	142	486	1,113	43	1,784	54.3%	91	332	516	31
Pasquotank	18.0%	34	511	1,352	3,233	91	5,187	57.2%	367	946	1,594	60
Perquimans	22.2%	11	253	577	1,323	50	2,204	67.3%	215	448	784	36
Pitt	16.1%	74	1,427	3,838	10,188	182	15,634	55.6%	1,012	2,667	4,908	108
Tyrrell	18.2%	60	75	183	487	17	761	59.3%	51	124	265	11
Washington	20.3%	6	315	899	1,705	43	2,962	66.2%	244	693	995	30
Wayne	14.9%	69	1,555	3,829	9,216	187	14,787	46.8%	1,016	2,333	3,452	117
Wilson	19.1%	21	1,202	3,936	7,187	172	12,497	62.3%	912	3,088	3,670	117

SOURCES: PERCENT OF TOTAL POPULATION UNINSURED--includes estimated average daily number of persons without any type of health insurance in 1985 divided by total population. The method for computing this figure is described below.

1985 ESTIMATED TOTAL PERSONS UNINSURED--is the sum of all poor and non-poor persons without insurance. The method for estimating uninsured poor is described below. For the non-poor, the total number without insurance was estimated as follows. The total population in each age category shown was estimated by multipling the fraction in each age category (from the 1980 Census) to total 1985 population and subtracting the estimated poverty population. The number of uninsured within each group was estimated by multiplying age-specific population times the average statewide rate of being uninsured in that age group times the lack of group health benefits index shown in Table 3. For persons above poverty, the rate of being uninsured is 8.3 percent for children under 6, 10.3 percent for children 6 to 17, 10.1 percent for adults 18-64 and 1.6 percent for the elderly.

PERCENT UNINSURED WHO ARE BELOW POVERTY--equals total number of uninsured poor divided by total number of uninsured.

1985 ESTIMATED TOTAL UNINSURED POOR--the figures are estimated based on the fraction of poor adults without insurance in each county, reported in Blakely, et al., **Geographic Distribution of the Medically Indigent Uninsured Poor and of Inpatient Care Patterns in North Carolina** (Chapel Hill: University of North Carolina, March 1986). 1985 poverty rates for each age category were obtained by multiplying the 1980 county-specific poverty rate for that age by the statewide increase in poverty rates for that age group (these rates of increase were: 49% for children under 6, 24% for children 6-17, 2% for adults 18-64 and a 7% decline for the elderly). These adjusted rates were multiplied by total 1985 population in each age group to yield total poverty population. The rate of being uninsured within each age category was estimated by multiplying the average statewide rate of being uninsured times the ratio of the adult uninsured poor rate in the county compared to the state (e.g., if poor adults were 10% more likely to be uninsured based on the Blakely et al. figures, poor children were also assumed to have a 10 percent higher uninsurance rate compared to the state average). For persons below poverty, the estimated likelihood of being without insurance is 42% for children under 6, 50.4% for children 6-17, 45.2% for adults 18-64 and 5.1% for the elderly.

Table 6

NUMBER OF MEDICAID AND MEDICARE ELIGIBLES BY CATEGORY

COUNTY	1985 ANNUAL MEDICAID ENROLLED									1984 DAILY MEDICARE ENROLLED			
	Aged	Blind	Disabled	AFDC	Other	Total	Pct. Aged	Pct. Dis.	Pct. AFDC	Aged	Disabled	Total	Pct. Aged
STATE TOTAL	65,849	1,634	48,349	293,188	5,333	414,353	16%	12%	71%	661,369	90,770	752,139	88%
HSA I	12,158	318	7,492	31,550	1,023	52,541	23%	14%	60%	137,690	17,206	154,896	89%
Alexander	216	5	131	369	31	752	29%	17%	49%	2,375	364	2,739	87%
Allegheny	121	3	93	301	3	521	23%	18%	58%	1,532	215	1,747	88%
Ashe	462	9	262	735	11	1,479	31%	18%	50%	3,296	420	3,716	89%
Avery	314	7	158	335	13	821	38%	19%	41%	1,983	273	2,256	88%
Buncombe	1,397	77	1,010	4,115	195	6,794	21%	15%	61%	23,651	2,656	26,307	90%
Burke	594	23	430	1,969	52	3,068	19%	14%	64%	7,660	1,531	9,191	83%
Caldwell	559	17	446	1,918	96	3,035	18%	15%	63%	6,854	1,080	7,934	86%
Catawba	773	11	531	3,007	117	4,439	17%	12%	68%	11,934	1,531	13,465	89%
Cherokee	380	18	163	567	23	1,151	33%	14%	49%	3,065	454	3,519	87%
Clay	178	3	78	200	6	465	38%	17%	43%	1,241	129	1,370	91%
Cleveland	946	9	622	4,581	112	6,270	15%	10%	73%	10,216	1,388	11,604	88%
Graham	159	0	72	297	4	532	30%	14%	56%	1,058	136	1,196	88%
Haywood	616	19	435	1,688	11	2,763	22%	16%	61%	6,910	828	7,738	89%
Henderson	550	16	320	1,503	55	2,444	23%	13%	61%	11,876	903	12,779	93%
Jackson	390	5	183	818	17	1,413	28%	13%	58%	3,050	354	3,404	90%
Macon	305	1	136	325	7	778	40%	17%	42%	4,345	385	4,730	92%
Madison	527	13	363	815	13	1,691	31%	19%	48%	2,572	278	2,850	90%
McDowell	475	7	294	1,120	60	1,956	24%	15%	57%	4,470	687	5,157	87%
Mitchell	345	2	194	386	20	947	36%	20%	41%	2,288	324	2,612	88%
Polk	158	4	73	208	13	456	34%	16%	46%	2,940	225	3,165	93%
Rutherford	775	14	426	2,226	52	3,495	22%	12%	64%	7,690	971	8,661	89%
Swain	239	5	111	648	3	1,006	23%	11%	65%	1,696	217	1,913	89%
Transylvania	238	5	151	686	10	1,089	22%	14%	63%	3,383	323	3,706	91%
Watauga	281	11	171	724	32	1,219	23%	14%	59%	3,036	332	3,368	90%
Wilkes	849	26	500	1,507	55	2,937	29%	17%	51%	6,351	939	7,290	87%
Yancey	320	8	186	506	12	1,032	31%	18%	49%	2,218	261	2,479	89%
HSA II	10,056	281	7,635	42,516	1,047	61,535	16%	12%	69%	129,698	16,545	146,243	89%
Alamance	877	11	653	3,051	103	4,695	19%	14%	65%	13,671	1,694	15,365	89%
Caswell	340	5	325	1,186	21	1,877	18%	17%	63%	1,962	323	2,285	86%
Davidson	869	17	624	3,565	152	5,218	16%	12%	68%	11,366	1,660	13,026	87%
Davie	246	4	157	495	16	918	27%	17%	54%	2,871	374	3,245	88%
Forsyth	2,061	67	1,798	12,364	176	16,466	13%	11%	75%	28,002	3,158	31,160	90%
Guilford	2,443	111	1,945	13,836	365	18,720	13%	10%	74%	35,874	4,325	40,199	89%
Randolph	651	14	417	1,330	84	2,496	26%	17%	53%	10,159	1,372	11,531	88%
Rockingham	1,013	12	810	3,581	47	5,462	19%	15%	66%	10,595	1,649	12,244	87%
Stokes	360	14	219	825	6	1,424	25%	15%	58%	2,954	351	3,305	89%
Surry	850	18	492	1,695	28	3,087	28%	16%	55%	8,441	1,194	9,635	88%
Yadkin	355	8	195	585	29	1,172	30%	17%	50%	3,801	445	4,246	90%
HSA III	7,927	195	5,824	45,175	966	60,087	13%	10%	75%	109,478	14,374	123,852	88%
Cabarrus	757	18	485	2,728	72	4,060	19%	12%	67%	12,285	1,569	13,854	89%
Gaston	1,419	43	1,096	8,432	96	11,086	13%	10%	76%	18,074	2,868	20,942	86%
Iredell	755	30	482	3,141	58	4,466	17%	11%	70%	10,309	1,264	11,573	89%
Lincoln	376	9	258	1,423	31	2,097	18%	12%	68%	4,518	665	5,183	87%
Mecklenburg	2,806	64	2,312	22,070	477	27,729	10%	8%	80%	38,878	4,590	43,468	89%
Rowan	795	17	573	2,876	109	4,370	18%	13%	66%	12,650	1,716	14,366	88%
Stanly	442	9	250	1,370	40	2,111	21%	12%	65%	6,582	841	7,423	89%
Union	577	5	368	3,135	83	4,168	14%	9%	75%	6,182	861	7,043	88%
HSA IV	8,957	299	6,579	35,478	665	51,978	17%	13%	68%	84,897	11,709	96,606	88%
Chatham	345	5	259	960	21	1,590	22%	16%	60%	3,709	458	4,167	89%
Durham	1,419	65	1,183	7,817	192	10,670	13%	11%	73%	16,787	2,205	18,992	88%
Franklin	742	15	364	1,785	24	2,930	25%	12%	61%	3,567	503	4,070	88%
Granville	391	8	266	1,593	25	2,279	17%	12%	70%	4,010	919	4,929	81%
Johnston	1,226	11	874	3,089	33	5,333	25%	16%	58%	8,338	1,414	9,752	86%
Lee	444	17	368	1,991	44	2,864	16%	13%	70%	4,507	698	5,205	87%
Orange	371	18	350	1,632	56	2,416	15%	14%	68%	5,936	578	6,514	91%
Person	474	22	378	1,585	22	2,481	19%	15%	64%	3,569	444	4,013	89%
Vance	625	10	519	3,254	32	4,490	15%	12%	72%	4,743	703	5,446	87%
Wake	2,377	114	1,754	10,093	210	14,526	16%	12%	69%	27,411	3,523	30,934	89%
Warren	431	14	277	1,673	4	2,399	18%	12%	70%	2,320	264	2,584	90%

COUNTY	1985 ANNUAL MEDICAID ENROLLED									1984 DAILY MEDICARE ENROLLED			
	Aged	Blind	Disabled	AFDC	Other	Total	Pct. Aged	Pct. Dis.	Pct. AFDC	Aged	Disabled	Total	Pct. Aged
HSA V	11,516	238	9,691	65,839	808	88,092	13%	11%	75%	86,459	14,444	100,903	86%
Anson	513	10	284	1,671	9	2,487	21%	11%	67%	3,211	454	3,665	88%
Bladen	594	11	505	2,548	10	3,668	16%	14%	69%	3,137	642	3,779	83%
Brunswick	509	11	416	2,236	9	3,181	16%	13%	70%	4,545	825	5,37[illegible]	85%
Columbus	1,049	2	865	4,762	37	6,715	16%	13%	71%	5,960	1,170	7,130	84%
Cumberland	1,356	64	1,622	16,943	302	20,287	7%	8%	84%	12,537	2,491	15,028	83%
Harnett	949	23	703	4,010	53	5,738	17%	12%	70%	5,965	977	6,942	86%
Hoke	271	12	238	1,994	20	2,535	11%	9%	79%	1,306	235	1,541	85%
Montgomery	340	11	220	1,027	11	1,609	21%	14%	64%	2,666	426	3,092	86%
Moore	566	5	362	1,546	30	2,509	23%	14%	62%	8,622	745	9,367	92%
New Hanover	935	29	919	6,703	88	8,674	11%	11%	77%	11,744	1,669	13,413	88%
Pender	417	4	276	1,625	11	2,333	18%	12%	70%	2,839	441	3,280	87%
Richmond	601	17	418	2,254	37	3,327	18%	13%	68%	5,346	1,042	6,388	84%
Robeson	1,975	21	1,753	11,685	131	15,569	13%	11%	75%	9,894	1,916	11,810	84%
Sampson	855	10	560	3,027	29	4,481	19%	12%	68%	5,632	806	6,438	87%
Scotland	586	8	550	3,804	31	4,979	12%	11%	76%	3,055	605	3,660	83%
HSA VI	15,235	303	11,128	72,630	824	100,120	15%	11%	73%	112,813	16,438	129,251	87%
Beaufort	559	6	395	2,112	21	3,093	18%	13%	68%	5,556	679	6,235	89%
Bertie	492	8	369	1,839	17	2,725	18%	14%	67%	2,883	423	3,306	87%
Camden	73	3	36	263	2	377	19%	10%	70%	685	91	776	88%
Carteret	435	4	291	1,099	27	1,856	23%	16%	59%	4,964	596	5,560	89%
Chowan	251	8	150	643	9	1,061	24%	14%	61%	1,960	222	2,182	90%
Craven	790	10	660	3,706	53	5,221	15%	13%	71%	6,628	915	7,543	88%
Currituck	84	0	75	320	13	492	17%	15%	65%	1,470	205	1,675	88%
Dare	103	5	50	270	14	442	23%	11%	61%	1,883	179	2,062	91%
Duplin	794	18	510	2,556	19	3,899	20%	13%	66%	4,798	698	5,496	87%
Edgecombe	979	25	740	6,263	44	8,051	12%	9%	78%	7,495	964	8,459	89%
Gates	165	2	87	490	7	751	22%	12%	65%	1,334	125	1,459	91%
Greene	259	2	194	1,459	9	1,923	13%	10%	76%	1,384	189	1,573	88%
Halifax	1,100	27	1,000	7,765	59	9,951	11%	10%	78%	7,455	1,131	8,586	87%
Hertford	528	12	308	1,926	22	2,796	19%	11%	69%	2,972	399	3,371	88%
Hyde	125	5	71	393	1	595	21%	12%	66%	887	102	989	90%
Jones	214	2	165	753	8	1,142	19%	14%	66%	1,148	177	1,325	87%
Lenoir	961	26	694	4,235	42	5,958	16%	12%	71%	7,021	1,483	8,504	83%
Martin	386	7	308	1,836	14	2,551	15%	12%	72%	3,246	511	3,757	86%
Nash	1,176	17	761	4,371	54	6,379	18%	12%	69%	6,816	974	7,790	87%
Northampton	582	10	407	2,873	8	3,880	15%	10%	74%	3,073	453	3,526	87%
Onslow	664	20	505	3,045	86	4,320	15%	12%	70%	4,833	748	5,581	87%
Pamlico	185	3	105	709	4	1,006	18%	10%	70%	1,338	156	1,494	90%
Pasquotank	321	6	201	1,911	25	2,464	13%	8%	78%	3,704	420	4,124	90%
Perquimans	169	1	116	800	11	1,099	15%	11%	73%	1,530	165	1,695	90%
Pitt	1,249	24	1,042	7,175	105	9,599	13%	11%	75%	9,162	1,413	10,575	87%
Tyrrell	113	2	68	412	0	595	19%	11%	69%	621	67	688	90%
Washington	188	6	169	1,420	4	1,787	11%	9%	79%	1,689	225	1,914	88%
Wayne	1,252	27	974	6,494	69	8,816	14%	11%	74%	9,241	1,722	10,963	84%
Wilson	1,039	17	670	5,486	77	7,289	14%	9%	75%	7,037	1,006	8,043	87%

SOURCES: 1985 ANNUAL MEDICAID ENROLLED--includes all persons who were enrolled in Medicaid at any time during state fiscal year 1985, regardless of whether they received any medical services through Medicaid. Figures include categorically needy persons who qualify for Medicaid because they receive public cash assistance, as well as medically needy individuals with somewhat higher incomes who may qualify through "spend-down". AFDC figures include both children and adults in qualified families with dependent children. Note that additional individuals in a county may be technically eligible for Medicaid but decline to participate. Unpublished data obtained from Division of Medical Assistance.

1984 DAILY MEDICARE ENROLLED--includes all persons enrolled in Medicare on July 1, 1984. Figures include persons who are eligible for either Part A and/or Part B Medicare coverage. Statewide total include 334 aged and 54 disabled enrollees with unknown county of residence. Unpublished data obtained from Health Care Financing Administration.

AVAILABILITY OF MEDICAL SERVICES

Distribution of Physicians, by Specialty

Availability of Primary Care

Availability of Inpatient Care

Availability of Alternative Delivery Systems

Table 7

DISTRIBUTION OF PHYSICIANS, BY SPECIALTY

COUNTY	TOTAL NUMBER OF PHYSICIANS	PRIMARY CARE PHYSICIANS: Family Practice	General Practice	Internal Medicine	Obstetrics/ Gynecology	Pediatrics	No Specialty	ALL OTHER SPECIALTIES
STATE TOTAL	9,094	12.6%	3.7%	12.0%	6.3%	6.9%	5.2%	53.2%
HSA I	1,345	20.3%	5.9%	10.2%	5.5%	5.7%	5.1%	47.4%
Alexander	10	80.0%	10.0%	0.0%	0.0%	0.0%	0.0%	10.0%
Allegheny	6	50.0%	0.0%	16.7%	0.0%	0.0%	0.0%	33.3%
Ashe	15	40.0%	6.7%	6.7%	13.3%	0.0%	0.0%	33.3%
Avery	24	41.7%	4.2%	8.3%	4.2%	0.0%	8.3%	33.3%
Buncombe	371	14.3%	2.4%	10.2%	4.0%	5.1%	6.5%	57.4%
Burke	106	13.2%	6.6%	9.4%	7.5%	7.5%	4.7%	50.9%
Caldwell	52	15.4%	19.2%	19.2%	5.8%	7.7%	1.9%	30.8%
Catawba	149	19.5%	3.4%	9.4%	8.7%	2.7%	5.4%	51.0%
Cherokee	22	31.8%	9.1%	18.2%	4.5%	4.5%	9.1%	22.7%
Clay	3	0.0%	66.7%	0.0%	0.0%	0.0%	0.0%	33.3%
Cleveland	96	19.8%	6.3%	5.2%	6.3%	6.3%	2.1%	54.2%
Graham	4	75.0%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Haywood	59	27.1%	1.7%	6.8%	3.4%	6.8%	5.1%	49.2%
Henderson	98	14.3%	4.1%	14.3%	5.1%	4.1%	7.1%	51.0%
Jackson	43	16.3%	11.6%	4.7%	4.7%	9.3%	9.3%	44.2%
Macon	30	20.0%	10.0%	6.7%	6.7%	10.0%	6.7%	40.0%
Madison	8	37.5%	12.5%	12.5%	12.5%	12.5%	0.0%	12.5%
McDowell	20	50.0%	20.0%	5.0%	0.0%	5.0%	5.0%	15.0%
Mitchell	21	42.9%	4.8%	19.0%	4.8%	4.8%	4.8%	19.0%
Polk	23	21.7%	4.3%	17.4%	4.3%	0.0%	0.0%	52.2%
Rutherford	45	15.6%	8.9%	11.1%	6.7%	6.7%	2.2%	48.9%
Swain	10	30.0%	30.0%	0.0%	0.0%	0.0%	10.0%	30.0%
Transylvania	28	21.4%	7.1%	17.9%	7.1%	3.6%	7.1%	35.7%
Watauga	56	16.1%	5.4%	8.9%	7.1%	12.5%	1.8%	48.2%
Wilkes	37	27.0%	5.4%	13.5%	5.4%	10.8%	5.4%	32.4%
Yancey	9	88.9%	0.0%	0.0%	0.0%	11.1%	0.0%	0.0%
HSA II	1,783	12.4%	2.5%	12.3%	5.7%	6.9%	3.7%	56.5%
Alamance	123	16.3%	4.1%	13.0%	7.3%	5.7%	2.4%	51.2%
Caswell	3	33.3%	33.3%	0.0%	0.0%	0.0%	0.0%	33.3%
Davidson	74	18.9%	8.1%	13.5%	9.5%	9.5%	4.1%	36.5%
Davie	18	33.3%	5.6%	5.6%	5.6%	0.0%	0.0%	50.0%
Forsyth	807	7.6%	1.4%	11.9%	4.8%	6.9%	4.2%	63.2%
Guilford	558	9.5%	2.2%	14.0%	6.3%	7.5%	2.9%	57.7%
Randolph	56	28.6%	1.8%	8.9%	3.6%	7.1%	5.4%	44.6%
Rockingham	66	27.3%	4.5%	12.1%	7.6%	6.1%	4.5%	37.9%
Stokes	11	36.4%	18.2%	9.1%	0.0%	9.1%	0.0%	27.3%
Surry	50	40.0%	4.0%	2.0%	6.0%	2.0%	8.0%	38.0%
Yadkin	17	47.1%	5.9%	17.6%	0.0%	5.9%	0.0%	23.5%
HSA III	1,361	10.1%	3.5%	13.4%	8.2%	6.8%	4.8%	53.3%
Cabarrus	92	5.4%	4.3%	18.5%	6.5%	8.7%	2.2%	54.3%
Gaston	139	16.5%	5.8%	12.9%	7.2%	7.2%	2.9%	47.5%
Iredell	96	13.5%	2.1%	13.5%	10.4%	5.2%	3.1%	52.1%
Lincoln	32	18.8%	12.5%	18.8%	6.3%	3.1%	3.1%	37.5%
Mecklenburg	816	6.7%	1.2%	13.1%	8.6%	6.9%	6.0%	57.5%
Rowan	95	14.7%	11.6%	13.7%	6.3%	6.3%	2.1%	45.3%
Stanly	37	24.3%	10.8%	13.5%	8.1%	5.4%	2.7%	35.1%
Union	54	22.2%	7.4%	7.4%	7.4%	7.4%	7.4%	40.7%
HSA IV	2,454	8.2%	1.5%	13.0%	5.2%	8.1%	5.7%	58.3%
Chatham	25	24.0%	0.0%	24.0%	4.0%	8.0%	20.0%	20.0%
Durham	949	5.2%	0.3%	13.4%	4.4%	6.6%	5.1%	65.0%
Franklin	12	41.7%	25.0%	0.0%	0.0%	0.0%	16.7%	16.7%
Granville	45	17.8%	4.4%	8.9%	2.2%	13.3%	2.2%	51.1%
Johnston	44	15.9%	11.4%	20.5%	4.5%	4.5%	0.0%	43.2%
Lee	50	30.0%	4.0%	16.0%	6.0%	6.0%	6.0%	32.0%
Orange	656	5.8%	0.6%	13.7%	5.2%	8.8%	7.8%	58.1%
Person	16	25.0%	12.5%	12.5%	6.3%	6.3%	6.3%	31.3%
Vance	32	31.3%	3.1%	6.3%	9.4%	6.3%	0.0%	43.8%
Wake	619	9.5%	2.6%	11.3%	6.3%	9.9%	4.4%	56.1%
Warren	6	16.7%	0.0%	0.0%	16.7%	0.0%	50.0%	16.7%

COUNTY	TOTAL NUMBER OF PHYSICIANS	PRIMARY CARE PHYSICIANS: Family Practice	General Practice	Internal Medicine	Obstetrics/ Gynecology	Pediatrics	No Specialty	ALL OTHER SPECIALTIES
HSA V	921	15.2%	5.8%	11.3%	8.1%	6.3%	5.5%	47.8%
Anson	15	33.3%	6.7%	13.3%	0.0%	0.0%	6.7%	40.0%
Bladen	18	27.8%	16.7%	11.1%	5.6%	11.1%	0.0%	27.8%
Brunswick	27	29.6%	11.1%	14.8%	7.4%	3.7%	3.7%	29.6%
Columbus	40	17.5%	12.5%	17.5%	7.5%	5.0%	7.5%	32.5%
Cumberland	227	15.9%	0.9%	8.8%	9.7%	7.5%	9.3%	48.0%
Harnett	39	33.3%	12.8%	5.1%	5.1%	5.1%	5.1%	33.3%
Hoke	8	37.5%	12.5%	37.5%	0.0%	0.0%	12.5%	0.0%
Montgomery	18	33.3%	16.7%	11.1%	0.0%	0.0%	0.0%	38.9%
Moore	101	4.0%	6.9%	9.9%	6.9%	4.0%	2.0%	66.3%
New Hanover	233	5.6%	0.4%	12.9%	11.6%	6.4%	3.4%	59.7%
Pender	7	42.9%	0.0%	28.6%	0.0%	0.0%	0.0%	28.6%
Richmond	29	31.0%	10.3%	3.4%	6.9%	3.4%	6.9%	37.9%
Robeson	87	16.1%	9.2%	11.5%	5.7%	6.9%	8.0%	42.5%
Sampson	43	20.9%	14.0%	14.0%	2.3%	9.3%	7.0%	32.6%
Scotland	29	17.2%	17.2%	10.3%	10.3%	13.8%	0.0%	31.0%
HSA VI	1,230	14.1%	6.3%	10.8%	6.9%	6.7%	6.7%	48.5%
Beaufort	46	15.2%	2.2%	10.9%	8.7%	6.5%	2.2%	54.3%
Bertie	10	20.0%	0.0%	10.0%	0.0%	0.0%	40.0%	30.0%
Camden	1	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Carteret	51	11.8%	17.6%	9.8%	7.8%	5.9%	0.0%	47.1%
Chowan	18	22.2%	5.6%	11.1%	5.6%	11.1%	0.0%	44.4%
Craven	110	7.3%	4.5%	7.3%	9.1%	6.4%	7.3%	58.2%
Currituck	3	66.7%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%
Dare	15	46.7%	6.7%	6.7%	0.0%	0.0%	13.3%	26.7%
Duplin	27	40.7%	11.1%	18.5%	3.7%	3.7%	7.4%	14.8%
Edgecombe	37	24.3%	2.7%	16.2%	16.2%	8.1%	0.0%	32.4%
Gates	3	66.7%	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%
Greene	4	50.0%	0.0%	25.0%	0.0%	25.0%	0.0%	0.0%
Halifax	48	8.3%	16.7%	10.4%	6.3%	4.2%	8.3%	45.8%
Hertford	24	33.3%	4.2%	12.5%	0.0%	8.3%	4.2%	37.5%
Hyde	3	66.7%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%
Jones	9	11.1%	0.0%	55.6%	0.0%	0.0%	0.0%	33.3%
Lenoir	80	8.8%	6.3%	12.5%	8.8%	8.8%	7.5%	47.5%
Martin	16	18.8%	37.5%	6.3%	12.5%	6.3%	6.3%	12.5%
Nash	97	12.4%	2.1%	14.4%	7.2%	8.2%	2.1%	53.6%
Northampton	9	11.1%	44.4%	11.1%	0.0%	11.1%	22.2%	0.0%
Onslow	71	11.3%	8.5%	5.6%	7.0%	5.6%	12.7%	49.3%
Pamlico	4	25.0%	75.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pasquotank	52	5.8%	1.9%	13.5%	13.5%	9.6%	11.5%	44.2%
Perquimans	2	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pitt	269	14.1%	0.0%	7.4%	5.9%	7.1%	8.2%	57.2%
Tyrrell	0	NA	NA	NA	NA	NA	NA	NA
Washington	8	12.5%	37.5%	12.5%	12.5%	0.0%	12.5%	12.5%
Wayne	118	9.3%	14.4%	7.6%	4.2%	5.1%	5.1%	54.2%
Wilson	95	11.6%	0.0%	17.9%	6.3%	7.4%	5.3%	51.6%

SOURCES: Health Services Research Center, North Carolina Health Manpower Data Book, Effective October, 1985 (Chapel Hill: University of North Carolina, 1986).

TOTAL NUMBER OF PHYSICIANS--total number of non-federal physicians by location of their primary place of practice (not residence), as of October, 1985. All National Health Service Corps physicians are included (even those on federal salary), but federal physicians practicing on military installations are excluded. Figures also exclude all resident physicians in postgraduate medical education programs at Duke University, UNC-Chapel Hill, Bowman Gray-North Carolina Baptist Hospitals, Moses Cone Hospital, Charlotte Memorial Hospital, New Hanover Memorial Hospital, Mountain AHEC in Asheville, Eastern AHEC in Greenville, Fayetteville AHEC, John Umstead Hospital or Pitt County Memorial Hospital. The totals include all physicians in "active" or "unknown" activity status. Active status includes all physicians in active practice status, regardless of whether it is full-time or part-time. Status not known includes anyone not reported as "active" or "inactive". Generally, these are newly-licensed individuals, so can be regarded as "active."

Table 8

AVAILABILITY OF PRIMARY CARE

COUNTY	TOTAL PRIMARY CARE PHYSICIANS Active Status	TOTAL PRIMARY CARE PHYSICIANS Status Not Known	ACTIVE MID-LEVEL PRACTITIONERS	POPULATION PER PRIMARY CARE PROVIDER All Persons	POPULATION PER PRIMARY CARE PROVIDER Poor Persons	POPULATION PER PRIMARY CARE PROVIDER Uninsured Poor	RANKING All	RANKING Poor	RANKING UIP
STATE TOTAL	3,944	314	1,051	1,173	190	76			
HSA I	667	41	181	1,204	182	73			
Alexander	9	0	1	2,688	255	59	14	60	84
Allegheny	4	0	1	2,006	429	234	30	25	20
Ashe	10	0	4	1,682	417	230	43	28	22
Avery	12	4	2	838	165	92	95	83	58
Buncombe	144	14	70	734	104	37	96	97	94
Burke	52	0	20	1,049	116	33	85	94	95
Caldwell	35	1	8	1,558	176	51	53	78	89
Catawba	67	6	11	1,334	120	41	65	93	92
Cherokee	16	1	3	1,008	244	136	90	63	49
Clay	2	0	0	3,576	886	382	6	7	9
Cleveland	44	0	9	1,595	230	80	51	67	69
Graham	4	0	0	1,776	378	209	41	35	26
Haywood	29	1	3	1,438	245	129	59	62	50
Henderson	42	6	13	1,087	146	63	83	89	79
Jackson	23	1	3	1,024	215	111	88	68	53
Macon	17	1	3	1,120	208	88	80	70	61
Madison	7	0	4	1,555	435	171	54	23	38
McDowell	17	0	1	2,045	262	61	29	58	81
Mitchell	17	0	0	841	154	84	94	88	66
Polk	11	0	3	1,056	158	69	84	85	74
Rutherford	22	1	0	2,480	370	196	16	37	31
Swain	6	1	1	1,369	386	215	61	32	24
Transylvania	16	2	3	1,201	168	39	75	82	93
Watauga	28	1	1	1,166	286	65	77	51	77
Wilkes	24	1	14	1,565	234	89	52	65	60
Yancey	9	0	3	1,293	331	184	71	41	34
HSA II	734	41	240	1,149	144	44			
Alamance	60	0	7	1,529	173	62	55	79	80
Caswell	2	0	3	4,465	946	532	4	4	3
Davidson	47	0	6	2,230	258	88	23	59	62
Davie	9	0	4	2,141	253	60	25	61	82
Forsyth	278	19	98	654	83	16	98	98	99
Guilford	227	9	87	1,015	124	42	89	92	91
Randolph	27	4	3	2,861	278	94	11	55	57
Rockingham	36	5	11	1,660	233	75	47	66	70
Stokes	8	0	2	3,560	488	115	7	20	51
Surry	27	4	16	1,286	192	73	72	74	71
Yadkin	13	0	3	1,860	288	67	34	49	76
HSA III	600	36	80	1,485	170	60			
Cabarrus	41	1	6	1,940	198	63	32	73	78
Gaston	71	2	9	2,076	238	82	27	64	68
Iredell	43	3	7	1,637	181	52	50	77	87
Lincoln	19	1	5	1,792	189	72	40	76	72
Mecklenburg	322	25	30	1,162	139	52	78	90	88
Rowan	50	2	16	1,515	162	55	57	84	85
Stanly	23	1	6	1,654	190	72	48	75	73
Union	31	1	1	2,367	267	87	20	57	64
HSA IV	936	88	267	687	103	37			
Chatham	17	3	7	1,307	130	30	67	91	96
Durham	309	23	111	363	56	17	99	99	98
Franklin	9	1	3	2,465	544	306	17	16	12
Granville	20	2	11	1,118	212	112	81	69	52
Johnston	25	0	4	2,583	505	174	15	19	36
Lee	30	4	4	1,045	155	83	86	87	61
Orange	242	33	62	243	40	11	100	100	100
Person	10	1	2	2,344	426	228	21	26	22
Vance	18	0	5	1,663	384	208	45	33	39
Wake	254	18	57	1,034	113	28	87	95	97
Warren	2	3	1	2,696	907	516	13	6	4

COUNTY	TOTAL PRIMARY CARE PHYSICIANS Active Status	TOTAL PRIMARY CARE PHYSICIANS Status Not Known	ACTIVE MID-LEVEL PRACTITIONERS	POPULATION PER PRIMARY CARE PROVIDER All Persons	POPULATION PER PRIMARY CARE PROVIDER Poor Persons	POPULATION PER PRIMARY CARE PROVIDER Uninsured Poor	RANKING -- All	RANKING -- Poor	RANKING -- Uninsured Poor
HSA V	433	48	132	1,547	322	151			
Anson	8	1	3	2,213	390	208	24	31	27
Bladen	12	1	3	1,933	542	306	33	17	11
Brunswick	19	0	2	2,108	460	244	26	22	18
Columbus	27	0	20	1,108	322	141	82	43	48
Cumberland	97	21	29	1,738	334	156	42	40	43
Harnett	23	3	6	1,976	420	185	31	27	33
Hoke	7	1	2	2,288	532	306	22	18	13
Montgomery	11	0	2	1,833	285	67	36	52	75
Moore	31	3	7	1,335	200	88	64	71	63
New Hanover	89	5	26	938	156	55	91	86	86
Pender	5	0	3	3,014	705	399	9	9	6
Richmond	15	3	4	2,061	343	183	28	38	35
Robeson	43	7	14	1,676	462	207	44	21	29
Sampson	26	3	8	1,369	319	170	62	45	39
Scotland	20	0	3	1,487	282	152	58	54	45
HSA VI	574	60	151	1,393	317	139			
Beaufort	20	1	5	1,660	383	204	46	34	30
Bertie	4	3	2	2,399	776	315	18	8	10
Camden	1	0	0	5,917	1,041	576	1	3	2
Carteret	25	2	10	1,302	199	86	68	72	65
Chowan	9	1	0	1,296	342	192	70	39	32
Craven	39	7	10	1,374	282	99	60	53	56
Currituck	3	0	0	4,506	909	397	3	5	7
Dare	9	2	8	873	107	45	93	96	90
Duplin	20	3	9	1,296	327	143	69	42	47
Edgecombe	23	2	7	1,823	407	166	37	29	40
Gates	2	1	0	3,061	665	267	8	11	14
Greene	4	0	3	2,394	671	384	19	10	8
Halifax	23	3	5	1,814	590	262	39	13	15
Hertford	14	1	5	1,198	321	172	76	44	37
Hyde	3	0	2	1,203	374	212	74	36	25
Jones	6	0	0	1,640	390	156	49	30	44
Lenoir	40	2	8	1,225	268	144	73	56	46
Martin	13	1	9	1,155	306	165	79	46	41
Nash	43	2	9	1,313	287	101	66	50	55
Northampton	7	2	3	1,854	574	233	35	14	21
Onslow	29	7	5	2,973	566	261	10	15	16
Pamlico	4	0	0	2,698	606	243	12	12	19
Pasquotank	24	5	4	875	170	90	92	81	59
Perquimans	2	0	0	4,953	1,329	742	2	1	1
Pitt	107	8	32	661	170	59	97	80	83
Tyrrell	0	0	1	4,171	1,146	452	5	2	5
Washington	7	0	1	1,820	434	245	38	24	17
Wayne	50	4	11	1,527	302	106	56	47	54
Wilson	43	3	2	1,360	299	162	63	48	[illegible]

SOURCES: Health Services Research Center, North Carolina Health Manpower Data Book, Effective October, 1985 (Chapel Hill: University of North Carolina, 1986).

TOTAL PRIMARY CARE PHYSICIANS--total number of non-federal primary care physicians by location of their primary place of practice (not residence), as of October, 1985. Primary care physicians include all those with a primary specialty of family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, or no specialty. See Table 7 for further explanation of which physicians are includedand excluded. Active status includes all physicians in active practice status, regardless of whether it is full-time or part-time. Status not known includes anyone not reported as "active" or "inactive". Generally, these are newly-licensed individuals, so can be regarded as "active."

ACTIVE MID-LEVEL PRACTITIONERS--total number of nurse practitioners and physician assistants as of October, 1984. These individuals are qualified by formal academic training to provide independent patient medical services under the direction of a physician.

POPULATION PER PRIMARY CARE PROVIDER--figures shown are computed by dividing total population by the combined total of primary care physicians (active and status unknown) and mid-level practitioners. This ratio overstates the availability of primary care manpower to the extent that manpower reported as "active" work less than full-time in direct patient care.

Table 9

AVAILABILITY OF INPATIENT CARE

COUNTY	FACILITIES WITH GENERAL SHORT-STAY HOSPITAL BEDS					POPULATION PER SHORT-STAY BED IN USE			RANKING		
	Number	Beds in Use	Public	Non-Profit	For-Profit	All Persons	Poor Persons	Uninsured Poor	All	Poor	Uninsured Poor
STATE TOTAL	130	21,154	46%	47%	7%	294	48	19			
HSA I	33	3,920	30%	64%	6%	273	41	16			
Alexander	1	62	0%	100%	0%	433	41	10	26	62	74
Allegheny	1	46	0%	100%	0%	218	47	25	66	56	36
Ashe	1	76	0%	100%	0%	310	77	42	46	22	16
Avery	2	93	0%	100%	0%	162	32	18	79	69	50
Buncombe	2	661	0%	100%	0%	253	36	13	57	65	65
Burke	2	295	0%	100%	0%	256	28	8	55	73	77
Caldwell	2	159	0%	81%	19%	431	49	14	27	54	62
Catawba	2	452	51%	0%	49%	248	22	8	59	80	78
Cherokee	2	111	45%	55%	0%	182	44	25	78	58	37
Clay	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cleveland	3	453	23%	77%	0%	187	27	9	76	75	75
Graham	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Haywood	1	200	100%	0%	0%	237	40	21	61	63	45
Henderson	2	336	69%	31%	0%	197	26	11	73	78	71
Jackson	1	80	0%	100%	0%	345	73	38	39	25	22
Macon	2	86	0%	100%	0%	274	51	22	52	48	44
Madison	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
McDowell	1	65	0%	100%	0%	566	73	17	7	24	52
Mitchell	1	92	0%	100%	0%	155	28	16	81	72	56
Polk	1	74	100%	0%	0%	200	30	13	72	71	63
Rutherford	1	165	0%	100%	0%	346	52	27	38	45	32
Swain	1	48	0%	100%	0%	228	64	36	63	31	23
Transylvania	1	64	0%	100%	0%	394	55	13	32	39	64
Watauga	2	169	83%	17%	0%	207	51	12	70	47	70
Wilkes	1	133	100%	0%	0%	459	69	26	20	28	34
Yancey	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
HSA II	20	3,855	8%	86%	6%	303	38	12			
Alamance	2	230	0%	100%	0%	446	51	18	22	49	48
Caswell	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Davidson	2	213	0%	100%	0%	555	64	22	11	32	42
Davie	1	66	100%	0%	0%	422	50	12	28	51	68
Forsyth	3	1335	0%	90%	10%	194	25	5	74	79	83
Guilford	5	1276	0%	92%	8%	257	31	11	54	70	72
Randolph	1	145	0%	100%	0%	671	65	22	2	29	41
Rockingham	2	254	0%	100%	0%	340	48	15	40	55	58
Stokes	1	60	100%	0%	0%	593	81	19	6	20	46
Surry	2	204	53%	47%	0%	296	44	17	49	57	53
Yadkin	1	72	100%	0%	0%	413	64	15	30	34	59
HSA III	15	3,914	56%	34%	10%	272	31	11			
Cabarrus	1	457	100%	0%	0%	204	21	7	71	82	80
Gaston	1	309	100%	0%	0%	551	63	22	12	35	43
Iredell	3	452	67%	0%	33%	192	21	6	75	81	81
Lincoln	1	110	100%	0%	0%	407	43	16	31	60	55
Mecklenburg*	6	1981	44%	44%	12%	221	27	10	65	76	73
Rowan	1	315	0%	100%	0%	327	35	12	43	66	69
Stanly	1	130	0%	100%	0%	382	44	17	34	59	54
Union	1	160	100%	0%	0%	488	55	18	16	40	49
HSA IV	19	3,628	52%	41%	8%	244	37	13			
Chatham	1	68	0%	100%	0%	519	52	12	13	44	67
Durham*	3	1307	34%	66%	0%	123	19	6	83	83	82
Franklin	1	54	100%	0%	0%	594	131	74	5	7	5
Granville	1	66	100%	0%	0%	559	106	56	10	10	9
Johnston	1	160	100%	0%	0%	468	92	32	17	14	26
Lee	1	142	0%	0%	100%	280	42	22	51	61	40
Orange	1	505	100%	0%	0%	162	26	8	80	77	79
Person	1	54	0%	100%	0%	564	103	55	8	11	11
Vance	1	100	0%	100%	0%	382	88	48	33	19	14
Wake	7	1135	53%	35%	12%	300	33	8	47	68	76
Warren	1	37	100%	0%	0%	437	147	84	24	4	1

COUNTY	FACILITIES WITH GENERAL SHORT-STAY HOSPITAL BEDS: Number	Beds in Use	Pub-lic	Non-Pro-fit	For-Pro-fit	POPULATION PER SHORT-STAY BED IN USE: All Persons	Poor Persons	Uninsured Poor	RANKING: All	Poor	UIP
HSA V	20	2,619	61%	34%	6%	362	75	35			
Anson	1	52	100%	0%	0%	511	90	48	14	17	13
Bladen	1	62	100%	0%	0%	499	140	79	15	5	2
Brunswick	2	100	100%	0%	0%	443	97	51	23	13	12
Columbus	1	166	100%	0%	0%	314	91	40	45	16	21
Cumberland	2	551	73%	0%	27%	464	89	42	18	18	18
Harnett	2	189	62%	38%	0%	335	71	31	42	26	27
Hoke*	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Montgomery	1	57	0%	100%	0%	418	65	15	29	30	57
Moore	2	247	0%	100%	0%	222	33	15	64	67	60
New Hanover	2	519	74%	26%	0%	217	36	13	67	64	66
Pender	1	43	100%	0%	0%	561	131	74	9	6	4
Richmond	2	122	100%	0%	0%	372	62	33	35	37	25
Robeson	1	240	0%	100%	0%	447	123	55	21	8	10
Sampson	1	146	100%	0%	0%	347	81	43	37	21	15
Scotland	1	125	0%	100%	0%	274	52	28	53	43	30
HSA VI	23	3,218	78%	16%	5%	340	77	34			
Beaufort	2	200	76%	25%	0%	216	50	27	68	52	33
Bertie	1	36	100%	0%	0%	600	194	79	4	1	3
Camden	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Carteret	2	143	82%	18%	0%	337	51	22	41	46	38
Chowan	1	70	100%	0%	0%	185	49	27	77	53	31
Craven	1	214	100%	0%	0%	360	74	26	36	23	35
Currituck	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Dare	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Duplin	1	68	100%	0%	0%	610	154	67	3	3	7
Edgecombe	1	127	0%	0%	100%	459	102	42	19	12	17
Gates	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Greene	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Halifax	2	200	90%	10%	0%	281	91	41	50	15	19
Hertford	1	100	0%	100%	0%	240	64	34	60	33	24
Hyde	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Jones	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Lenoir	1	247	100%	0%	0%	248	54	29	58	41	29
Martin	2	61	80%	20%	0%	436	115	62	25	9	8
Nash	2	310	85%	0%	15%	229	50	18	62	50	51
Northampton	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Onslow	1	150	100%	0%	0%	813	155	71	1	2	6
Pamlico	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Pasquotank	1	205	100%	0%	0%	141	27	14	82	74	61
Perquimans	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Pitt	1	469	100%	0%	0%	207	53	19	69	42	47
Tyrrell	0	0	NA	NA	NA	NA	NA	NA	NA	NA	NA
Washington	1	49	100%	0%	0%	297	71	40	48	27	20
Wayne	1	311	0%	100%	0%	319	63	22	44	36	39
Wilson	1	258	100%	0%	0%	253	56	30	56	38	28

SOURCES: FACILITIES WITH GENERAL SHORT-STAY HOSPITAL BEDS--figures shown represent the total number of facilities and beds in use as of September 30, 1985, based on the classification of beds used by the N.C. Division of Facility Services. Figures exclude all psychiatric beds (even if designated as short-stay) and all other specialty beds (rehabilitation beds). As noted, however, EENT beds are included. The percent of beds classified as public, non-profit, or for-profit is based on the type of ownership, not type of operation. Thus, for example, the figures do not fully reflect the extent to which public hospitals may be operated by non-profit or for-profit entities. Unpublished data obtained from Division of Facility Services.

POPULATION PER SHORT-STAY BED IN USE--total population in each category shown is divided by beds in use to yield the average number of persons per available bed. Note that this is only a very crude indicator of the likely demand for beds among, for example, the poor or uninsured poor. Even aside from the 17 counties without hospitals, there are 21 counties in which one-third or more of the Medicaid population crosses county lines to receive inpatient care. See Blakely, et al., **Geographic Distribution of the Medically Indigent Uninsured Poor and of Inpatient Care Patterns in North Carolina** (Chapel Hill: University of North Carolina, March 1986).

* Figures for Durham include 16 EENT beds; figures for Mecklenburg include 68 EENT beds; and figures for Moore County exclude 95 short-stay beds at McCain Hospital since it is a prison hospital.

Table 10

AVAILABILITY OF ALTERNATIVE DELIVERY SYSTEMS

COUNTY	1985 UNINSURED POOR	PERCENT OF UNINSURED POOR WHO ARE LIVING IN ADS SERVICE AREA: Any Existing ADS	Any Potential ADS	Any ADS	Existing ADS: BC/BS Personal Care Plan	Health-America	Kaiser Health Plan	All Others*	Potential ADS: Rural Health Centers	Federal Health Centers	Health Depts. With Primary Care $ ** Children	Adults
STATE TOTAL	402,092	64.8%	69.5%	88.5%	57.6%	48.6%	24.7%	29.0%	21.1%	39.0%	8.3%	24.1%
HSA I	64,610	57.2%	54.3%	81.1%	43.9%	11.9%	5.3%	6.8%	10.3%	11.5%	5.9%	37.3%
Alexander	591	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Allegheny	1,169	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	50.0%	0.0%	100.0%
Ashe	3,220	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
Avery	1,656	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Buncombe	8,393	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Burke	2,395	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Caldwell	2,232	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	100.0%
Catawba	3,416	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Cherokee	2,720	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Clay	763	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Cleveland	4,244	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Graham	835	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Haywood	4,249	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Henderson	3,823	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	0.0%
Jackson	3,006	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Macon	1,852	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Madison	1,881	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
McDowell	1,106	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Mitchell	1,433	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%
Polk	969	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Rutherford	4,501	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Swain	1,721	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Transylvania	829	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Watauga	1,945	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Wilkes	3,454	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Yancey	2,206	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
HSA II	44,973	100.0%	64.0%	100.0%	83.7%	100.0%	0.0%	63.9%	19.2%	15.2%	14.6%	30.2%
Alamance	4,161	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%
Caswell	2,658	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%	0.0%
Davidson	4,674	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%
Davie	781	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Forsyth	6,386	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Guilford	13,590	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
Randolph	3,197	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Rockingham	3,889	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Stokes	1,153	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Surry	3,408	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%
Yadkin	1,076	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%
HSA III	42,682	100.0%	61.7%	100.0%	89.1%	100.0%	100.0%	75.5%	0.0%	46.0%	0.0%	15.7%
Cabarrus	3,046	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Gaston	6,707	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%
Iredell	2,767	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Lincoln	1,802	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Mecklenburg	19,625	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%
Rowan	3,721	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Stanly	2,152	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Union	2,862	100.0%	0.0%	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%
HSA IV	47,952	93.5%	90.9%	100.0%	87.3%	93.5%	87.0%	90.3%	9.4%	83.2%	0.0%	1.7%
Chatham	819	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%
Durham	7,386	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%
Franklin	3,973	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	50.0%	0.0%	0.0%
Granville	3,682	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%
Johnston	5,048	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%
Lee	3,137	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	50.0%	0.0%	100.0%	0.0%	0.0%
Orange	3,794	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%
Person	2,970	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%
Vance	4,777	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	50.0%	0.0%	0.0%
Wake	9,267	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%
Warren	3,099	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%

COUNTY	1985 UNINSURED POOR	PERCENT OF UNINSURED POOR WHO ARE LIVING IN ADS SERVICE AREA: Any Existing ADS	Any Potential ADS	Any ADS	Existing ADS: BC/BS Personal Care Plan	Existing ADS: Health-America	Existing ADS: Kaiser Health Plan	Existing ADS: All Others	Potential ADS: Rural Health Centers	Potential ADS: Federal Health Centers	Potential ADS: Health Depts. With Primary Care $ ** Children	Potential ADS: Health Depts. With Primary Care $ ** Adults
HSA V	92,389	45.3%	82.9%	86.2%	45.3%	6.4%	6.4%	0.0%	33.7%	46.6%	5.5%	40.8%
Anson	2,501	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%
Bladen	4,901	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%
Brunswick	5,124	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Columbus	6,645	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Cumberland	22,990	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%
Harnett	5,912	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Hoke	3,056	100.0%	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Montgomery	877	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Moore	3,599	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
New Hanover	6,561	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Pender	3,194	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Richmond	4,021	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Robeson	13,242	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%
Sampson	6,276	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	100.0%	0.0%	100.0%
Scotland	3,488	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
HSA VI	109,487	45.1%	63.1%	80.6%	40.2%	45.1%	5.0%	7.1%	31.0%	36.6%	16.4%	12.9%
Beaufort	5,311	100.0%	50.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%
Bertie	2,831	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Camden	576	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Carteret	3,190	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Chowan	1,923	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Craven	5,531	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	50.0%	100.0%	0.0%
Currituck	1,190	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Dare	862	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Duplin	4,562	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	0.0%	100.0%
Edgecombe	5,316	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	100.0%	100.0%	0.0%	100.0%
Gates	801	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%
Greene	2,690	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Halifax	8,126	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	0.0%	0.0%
Hertford	3,437	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Hyde	1,058	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Jones	934	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Lenoir	7,190	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Martin	3,801	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Nash	5,439	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Northampton	2,797	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Onslow	10,689	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pamlico	970	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%
Pasquotank	2,968	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Perquimans	1,483	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Pitt	8,695	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Tyrrell	452	0.0%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Washington	1,963	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Wayne	6,918	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Wilson	7,786	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%

SOURCES: Figures shown indicate counties within the market service area of existing alternative delivery systems as of June, 1986 (some counties are included if marketing in that county was anticipated by the end of calendar 1986). Existing ADS include all health maintenance organizations (HMOs) or preferred provider organizations (PPOs) known to be operational in the state. Entities which potentially could be put into an alternative delivery system network include rural health centers which receive or have received state assistance for start-up, federal community health centers, or local health departments which are currently receiving funding through the state primary care program. Figures indicate whether the primary care services offered through such departments are targeted chiefly at children or adults (or both). Data obtained through telephone contact by Center for Health Policy Research and Education.

NOTE: Figures shown may somewhat overstate the number of individuals actually residing in the service area of the alternative delivery system shown. Counties included in the service area either have delivery sites (e.g., participating physicians or clinics) or include residents within 30 miles of such sites located in neighboring counties. Figures represent service areas as of June 1986 except for Carolina Medical Plan, which includes counties that are part of their planned expansion into the Triangle by the end of 1986.

* Other plans include Triad Physicians Health Care Plan, Health Point Preferred, Med-Select of Guilford County, and Carolina Medical Care.

** Includes only counties which receive state funds for primary care.

SUMMARY OF PUBLIC INDIGENT-RELATED HEALTH EXPENDITURES

Total Expenditures for Indigent-Related Health Care, 1985

Indigent-Related Health Funding Available for Persons Below Poverty, 1985

Comparative Public Burden of Indigent Health Care, 1985

Table 11

TOTAL EXPENDITURES FOR INDIGENT-RELATED HEALTH CARE, 1985
(All Figures in Thousands)

COUNTY	FY85 LOCAL TOTAL	FY85 STATE TOTAL	FY85 FEDERAL TOTAL	TOTAL INDIGENT-RELATED HEALTH CARE	RANK	EXCLUDE LONG-TERM CARE*	RANK
STATE TOTAL	$119,524	$299,605	$456,575	$879,561		$553,936	
HSA I	14,853	42,994	73,326	131,653		72,072	
Alexander	324	925	1,468	2,721	79	1,437	81
Allegheny	151	393	559	1,108	96	821	92
Ashe	376	1,046	1,609	3,044	77	2,193	71
Avery	305	721	1,161	2,124	84	1,335	83
Buncombe	2,295	6,133	10,248	18,699	9	9,244	14
Burke	753	2,800	4,695	8,260	38	3,602	55
Caldwell	703	2,837	4,692	8,268	37	4,466	42
Catawba	1,475	3,245	7,045	12,165	17	6,105	27
Cherokee	297	1,052	1,709	3,070	76	1,775	76
Clay	119	412	723	1,257	94	743	93
Cleveland	1,456	3,475	6,488	11,511	21	6,013	28
Graham	106	388	653	1,152	95	696	95
Haywood	667	2,269	3,609	6,581	47	4,198	46
Henderson	873	2,135	3,916	6,938	42	3,621	52
Jackson	378	1,344	1,958	3,715	70	2,213	70
Macon	432	934	1,092	2,473	82	1,752	77
Madison	234	837	1,586	2,667	80	1,624	79
McDowell	395	1,559	2,742	4,701	61	2,154	72
Mitchell	141	685	1,208	2,041	85	1,188	85
Polk	226	526	857	1,652	91	915	91
Rutherford	706	2,213	4,597	7,909	39	4,585	40
Swain	158	571	960	1,694	89	1,129	87
Transylvania	179	961	1,941	3,194	72	1,591	80
Watauga	836	1,827	1,841	4,027	67	2,666	66
Wilkes	1,042	2,910	5,018	9,001	36	4,982	37
Yancey	128	596	951	1,683	90	1,150	86
HSA II	21,750	52,460	77,877	152,512		92,726	
Alamance	2,929	7,046	6,243	16,272	10	11,165	10
Caswell	634	1,538	1,722	3,895	68	2,919	60
Davidson	1,171	4,815	6,908	12,904	16	7,369	20
Davie	238	1,032	1,802	3,074	75	1,425	82
Forsyth	5,000	10,729	18,407	34,136	4	21,256	4
Guilford	8,398	14,118	22,414	45,220	2	27,989	3
Randolph	716	3,951	5,120	9,806	32	5,077	35
Rockingham	836	4,183	6,948	11,976	18	6,876	25
Stokes	1,126	1,376	2,350	4,862	60	3,027	57
Surry	455	2,435	3,951	6,854	44	3,885	49
Yadkin	252	1,233	2,012	3,514	71	1,742	78
HSA III	26,010	52,407	67,977	146,912		92,997	
Cabarrus	733	3,311	5,783	9,866	31	4,972	36
Gaston	2,011	7,145	12,114	21,389	7	12,165	9
Iredell	1,048	3,088	5,728	9,885	30	5,128	34
Lincoln	669	1,675	2,725	5,077	58	2,980	59
Mecklenburg	18,368	18,820	27,614	65,041	1	43,984	1
Rowan	834	10,377	6,037	10,274	28	5,134	33
Stanly	427	10,239	3,244	15,930	12	10,887	8
Union	1,920	2,754	4,731	9,450	34	5,806	29
HSA IV	23,541	49,781	62,592	136,264		95,287	
Chatham	412	2,787	2,410	5,608	55	3,862	50
Durham	7,144	8,757	13,589	29,522	5	20,581	5
Franklin	427	2,018	3,282	5,770	53	4,066	48
Granville	480	1,864	2,733	5,117	57	3,302	55
Johnston	2,451	5,362	7,017	14,873	14	9,847	11
Lee	466	2,620	3,366	6,455	48	4,208	45
Orange	1,315	5,192	3,779	10,300	27	7,720	16
Person	460	2,134	3,147	5,740	54	3,441	54
Vance	488	2,327	3,785	6,599	45	4,796	38
Wake	9,422	15,434	17,484	42,340	3	30,617	2
Warren	477	1,287	2,002	3,844	69	2,848	61

COUNTY	FY85 LOCAL TOTAL	FY85 STATE TOTAL	FY85 FEDERAL TOTAL	TOTAL INDIGENT-RELATED HEALTH CARE	RANK	EXCLUDE LONG-TERM CARE*	RANK
HSA V	16,412	49,108	79,698	145,886		99,523	
Anson	309	1,710	2,967	5,030	59	2,785	63
Bladen	394	2,202	3,619	6,255	50	4,337	43
Brunswick	1,095	1,721	3,140	5,995	52	4,127	47
Columbus	1,150	4,106	6,530	11,840	20	9,017	15
Cumberland	2,457	9,040	15,581	27,174	6	19,492	6
Harnett	845	3,920	6,248	11,042	25	7,066	22
Hoke	208	1,133	1,805	3,184	73	2,353	69
Montgomery	210	1,196	1,752	3,173	74	1,920	73
Moore	468	2,592	3,549	6,636	46	3,782	51
New Hanover	2,459	4,802	8,914	16,244	11	9,459	13
Pender	3,710	1,310	2,225	7,258	41	5,708	32
Richmond	442	2,613	3,844	6,934	43	4,479	41
Robeson	1,511	7,062	11,051	19,729	8	14,904	7
Sampson	740	3,422	4,876	9,050	35	5,775	31
Scotland	407	2,279	3,596	6,342	49	4,319	44
HSA VI	16,960	52,856	95,105	166,334		101,331	
Beaufort	551	2,000	3,477	6,054	51	3,040	56
Bertie	791	1,106	2,248	4,137	65	2,786	62
Camden	24	273	425	783	100	374	100
Carteret	596	1,769	3,000	5,359	56	2,749	65
Chowan	288	752	1,439	2,453	83	1,204	84
Craven	1,585	3,347	5,839	10,687	26	6,952	24
Currituck	133	378	536	1,052	97	537	98
Dare	179	542	852	1,578	92	723	94
Duplin	1,028	2,506	4,132	7,702	40	4,674	39
Edgecombe	1,188	3,635	6,713	11,258	23	7,020	23
Gates	92	436	812	1,354	93	675	96
Greene	201	898	1,785	2,929	78	1,875	74
Halifax	2,832	3,739	6,409	11,086	24	7,700	17
Hertford	2,000	1,308	2,466	4,091	66	2,596	68
Hyde	60	309	533	917	99	488	99
Jones	191	573	1,150	1,868	88	1,122	88
Lenoir	1,753	3,679	6,646	11,894	19	7,377	19
Martin	649	1,395	2,340	4,421	64	2,930	58
Nash	1,148	3,786	6,449	11,500	22	7,434	18
Northampton	2,252	1,355	2,886	4,586	63	2,762	64
Onslow	1,022	3,417	5,158	9,624	33	5,804	30
Pamlico	145	609	1,258	2,018	86	1,073	89
Pasquotank	401	1,577	2,667	4,697	62	2,606	67
Perquimans	158	623	1,137	1,930	87	981	90
Pitt	1,856	4,448	8,492	14,896	13	9,740	12
Tyrrell	61	295	580	942	98	539	97
Washington	285	861	1,459	2,624	81	1,870	75
Wayne	1,379	4,069	8,342	13,901	15	7,367	21
Wilson	845	3,179	5,875	9,990	29	6,330	26

SOURCES: Data compiled by Center for Health Policy Research & Education, Duke University. Figures include all funding for Medicaid (Federal FY85); area mental health programs (state FY85); Division of Health Services direct service delivery programs (primarily through local health departments, state FY85); county and city payments to hospitals for indigent care (FY85); and county or city payments to or on behalf of hospitals for repayment of long-term debt (FY85 payments only). See Tables 14 and 15 for a breakdown by of local, state, and federal totals for each of these separate programs.

* Excludes the following long term care services paid through Medicaid: skilled nursing facilities, intermediate care facilities, state mental hospital care for the elderly and persons under age 21, and hospital long term care services.

NOTE: Comparisons between counties must be made with caution for three major reasons. First, not all expenditures included in this table are exclusively for the medically indigent (e.g., county repayment of hospital revenue bonds). Second, the figures shown do not account for roughly $240 million in additional public spending on medical services which may benefit the medically indigent (the figures exclude an additional $370 million in hospital and physician free care). Programs which are not included in the figures shown are VA health services, Indian Health, rural health centers, federal community health centers, National Health Service Corps, WIC (nutrition supplements for pregnant women and children), perinatal care, Title XX sterilizations, state abortion fund, medical eye care, emergency medical services, medical vocational rehabilitation, developmental evaluation centers, crippled childrens services, Lenox Baker Childrens Hospital, alcohol rehabilitation centers and state mental hospitals. These programs were excluded due to lack of reliable county data or because they are statewide in focus and are theoretically available to all residents. Finally, in counties which are part of district health departments or multi-county area mental health programs, total funding for certain programs has been apportioned based on population. Thus, the figures only approximate the actual distribution of funds across counties.

Table 12

INDIGENT-RELATED HEALTH FUNDING AVAILABLE FOR
PERSONS BELOW POVERTY, 1985

COUNTY	PUBLIC INDIGENT-RELATED Local Funds/ Poor Person	Rank	Total Funds/ Poor Person	Rank	EXCLUDING LONG-TERM CARE Local Funds/ Poor Person	Rank	Total Funds/ Poor Person	Rank
STATE TOTAL	$118		$872		$103		$549	
HSA I	92		813		74		445	
Alexander	127	15	1,066	15	103	17	563	27
Allegheny	70	56	517	95	64	42	383	81
Ashe	64	66	521	94	58	51	375	84
Avery	79	45	714	70	66	41	449	58
Buncombe	95	30	792	49	76	32	392	79
Burke	90	34	992	25	64	44	432	65
Caldwell	91	33	1,066	16	68	39	576	24
Catawba	146	11	1,207	6	118	13	606	19
Cherokee	61	70	628	81	48	68	363	89
Clay	67	63	709	71	54	57	419	69
Cleveland	119	17	944	29	98	18	493	45
Graham	70	59	763	57	56	53	461	54
Haywood	82	41	813	46	69	36	518	41
Henderson	98	27	781	51	81	29	408	72
Jackson	65	65	639	79	53	58	381	82
Macon	99	25	567	90	91	23	401	74
Madison	49	89	557	91	39	87	339	93
McDowell	84	39	995	24	58	49	456	55
Mitchell	54	82	780	52	39	86	454	56
Polk	121	16	748	62	105	15	414	71
Rutherford	93	31	930	33	74	34	532	36
Swain	51	85	548	93	42	78	365	88
Transylvania	79	46	904	35	58	50	450	57
Watauga	98	29	469	97	90	24	311	95
Wilkes	114	19	988	26	93	21	540	30
Yancey	32	100	424	98	26	100	290	97
HSA II	149		1,044		130		635	
Alamance	252	5	1,401	3	231	5	961	4
Caswell	134	13	823	42	124	11	617	18
Davidson	86	38	943	30	67	40	539	32
Davie	70	57	933	32	47	71	433	64
Forsyth	153	10	1,042	17	134	10	649	13
Guilford	211	8	1,133	9	190	8	702	9
Randolph	76	50	1,037	20	52	62	537	34
Rockingham	69	61	987	27	49	65	567	26
Stokes	231	6	996	23	213	6	620	16
Surry	50	87	759	58	35	93	430	66
Yadkin	55	80	763	56	37	88	378	83
HSA III	214		1,210		193		766	
Cabarrus	77	47	1,039	18	52	60	524	38
Gaston	103	24	1,094	10	81	30	622	14
Iredell	109	21	1,031	21	86	26	534	35
Lincoln	141	12	1,073	13	120	12	618	17
Mecklenburg	350	2	1,238	5	331	2	837	5
Rowan	76	49	935	31	54	55	467	51
Stanly	75	51	2,791	1	49	64	2,258	1
Union	218	7	1,072	14	198	7	659	12
HSA IV	177		1,023		162		716	
Chatham	117	18	1,600	2	94	20	1,102	2
Durham	288	3	1,191	7	271	3	830	6
Franklin	60	71	815	45	49	66	575	25
Granville	69	62	733	65	56	52	473	49
Johnston	167	9	1,015	22	151	9	672	10
Lee	79	44	1,093	11	62	47	713	8
Orange	98	26	771	54	89	25	578	23
Person	83	40	1,037	19	64	46	622	15
Vance	55	81	751	61	45	72	542	29
Wake	254	4	1,143	8	239	4	825	7
Warren	88	36	706	73	79	31	523	39

COUNTY	PUBLIC INDIGENT-RELATED: Local Funds/ Poor Person	RANK	PUBLIC INDIGENT-RELATED: Total Funds/ Poor Person	RANK	EXCLUDING LONG-TERM CARE: Local Funds/ Poor Person	RANK	EXCLUDING LONG-TERM CARE: Total Funds/ Poor Person	RANK
HSA V	83		738		72		504	
Anson	66	64	1,075	12	43	74	595	21
Bladen	45	92	721	68	35	92	500	44
Brunswick	114	20	621	84	104	16	428	67
Columbus	76	48	783	50	68	38	596	20
Cumberland	50	88	553	92	43	77	397	78
Harnett	63	67	822	44	49	67	526	37
Hoke	39	98	598	87	32	96	442	61
Montgomery	57	78	857	39	41	81	519	40
Moore	57	77	811	47	41	80	462	53
New Hanover	131	14	868	37	114	14	505	42
Pender	658	1	1,286	4	645	1	1,012	3
Richmond	58	75	918	34	43	76	593	22
Robeson	51	86	667	77	43	75	504	43
Sampson	63	68	767	55	50	63	489	46
Scotland	63	69	977	28	48	69	665	11
HSA VI	68		669		56		407	
Beaufort	53	84	608	85	39	85	305	96
Bertie	105	23	592	89	96	19	399	77
Camden	71	55	752	60	53	59	359	90
Carteret	81	43	730	66	64	45	374	86
Chowan	70	60	717	69	52	61	352	92
Craven	87	37	676	76	75	33	440	63
Currituck	49	90	386	100	40	84	197	100
Dare	88	35	779	53	68	37	357	91
Duplin	98	28	735	64	84	27	446	59
Edgecombe	60	73	865	38	44	73	539	31
Gates	46	91	679	75	30	97	338	94
Greene	43	96	624	83	32	95	399	76
Halifax	45	93	606	86	36	91	421	68
Hertford	44	95	638	80	33	94	405	73
Hyde	37	99	490	96	26	99	261	98
Jones	56	79	798	48	41	79	479	47
Lenoir	109	22	887	36	93	22	550	28
Martin	92	32	628	82	82	28	416	70
Nash	74	53	742	63	61	48	479	48
Northampton	41	97	666	78	29	98	401	75
Onslow	44	94	415	99	36	90	250	99
Pamlico	60	72	833	41	41	83	443	60
Pasquotank	71	54	838	40	54	56	465	52
Perquimans	57	76	726	67	41	82	369	87
Pitt	74	52	595	88	64	43	389	80
Tyrrell	53	83	822	43	37	89	470	50
Washington	62	42	756	59	72	35	539	33
Wayne	70	58	708	72	54	54	375	85
Wilson	59	74	695	74	47	70	440	62

SOURCES: LOCAL FUNDS PER POOR PERSON--figure includes all county/city expenditures reported in Table 16 divided by total persons with incomes below poverty (see Table 1). Total funds include all federal, state and local expenditures reported in Table 16.

EXCLUDING LONG-TERM CARE--excludes the following long term care services paid through Medicaid: skilled nursing facilities, intermediate care facilities, state mental hospital care for the elderly and persons under age 21, and hospital long term care services.

NOTE: These estimates of funding per poor person overstate the actual amount of funding available to assist persons below poverty since not all funding shown is spent exclusively on below-poverty individuals. Medicaid, for example, accounts for roughly three-fourths of the funding shown (60 percent if long term care costs are excluded). Over one fourth of Medicaid acute care expenditures are for individuals above poverty. Similarly, other publicly funded services, such as immunizations, are available to the general public regardless of ability to pay. Nevertheless, the majority of funds are targeted at medically indigent individuals whose ability to pay is limited by lack of income or lack of insurance. The ratios therefore serve as a crude gauge of the relative distribution of funds compared to the population in need.

Table 13

COMPARATIVE PUBLIC BURDEN OF INDIGENT HEALTH CARE, 1985

COUNTY	PUBLIC INDIGENT-RELATED COSTS: County Share of Total	County Total/ $10000 Income	RANK	County Total/ Resident	RANK	EXCLUDING LONG-TERM CARE COSTS: County Share of Total	County Total/ $10000 Income	RANK	County Total/ Resident	RANK
STATE TOTAL	13.6%	$16.81		$19.19		18.8%	$14.64		$16.71	
HSA I	11.3%	13.16		13.87		16.7%	10.68		11.26	
Alexander	11.9%	11.14	71	12.05	68	18.4%	9.08	67	9.82	61
Allegheny	13.6%	16.25	38	15.06	36	16.8%	14.85	30	13.76	31
Ashe	12.4%	19.50	20	15.98	32	15.3%	17.43	19	14.29	27
Avery	11.0%	18.38	28	15.55	33	14.7%	15.41	26	13.03	34
Buncombe	12.0%	11.50	70	13.38	52	19.4%	9.22	65	10.73	51
Burke	9.1%	9.44	87	9.96	82	14.8%	6.70	89	7.08	86
Caldwell	8.5%	10.18	84	10.25	80	11.7%	7.59	83	7.64	82
Catawba	12.1%	10.48	81	13.16	58	19.5%	8.46	77	10.62	53
Cherokee	9.7%	19.69	18	14.72	39	13.3%	15.65	25	11.69	40
Clay	9.5%	21.45	16	16.63	29	12.8%	17.12	20	13.27	33
Cleveland	12.6%	16.72	35	17.22	27	19.9%	13.72	33	14.12	28
Graham	9.2%	18.63	25	14.89	38	12.2%	14.93	29	11.93	38
Haywood	10.1%	13.38	55	14.05	45	13.2%	11.13	51	11.69	41
Henderson	12.6%	10.76	77	13.16	57	19.8%	8.85	70	10.83	47
Jackson	10.2%	15.05	45	13.68	50	13.9%	12.27	39	11.15	44
Macon	17.5%	19.37	21	18.38	24	22.7%	17.85	17	16.93	22
Madison	8.8%	16.87	34	13.68	49	11.4%	13.34	35	10.82	48
McDowell	8.4%	10.90	74	10.72	79	12.8%	7.58	84	7.46	83
Mitchell	6.9%	10.52	79	9.87	84	8.5%	7.54	85	7.07	87
Polk	16.1%	15.10	44	18.03	25	25.3%	13.12	37	15.66	24
Rutherford	10.0%	13.76	52	13.81	48	13.9%	10.98	53	11.03	45
Swain	9.3%	18.28	29	14.42	43	11.6%	15.15	28	11.96	37
Transylvania	8.7%	9.96	85	11.05	77	12.8%	7.28	86	8.08	78
Watauga	20.8%	27.24	11	24.00	16	29.1%	25.16	10	22.17	14
Wilkes	11.6%	16.15	39	17.07	28	17.3%	13.18	36	13.92	29
Yancey	7.6%	10.80	75	8.27	96	9.0%	6.70	74	6.66	90
HSA II	14.3%	14.76		18.65		1.0%	12.84		16.22	
Alamance	18.0%	23.91	14	28.58	8	24.1%	21.94	13	26.23	9
Caswell	16.3%	37.44	2	28.42	9	20.2%	34.73	2	26.36	8
Davidson	9.1%	8.85	91	9.91	83	12.3%	6.88	87	7.70	80
Davie	7.5%	7.27	96	8.32	95	10.8%	4.82	97	5.52	97
Forsyth	14.6%	13.12	59	19.36	21	20.7%	11.52	49	17.00	21
Guilford	18.6%	18.45	27	25.61	11	27.1%	16.66	21	23.12	11
Randolph	7.3%	6.70	99	7.36	100	9.7%	4.59	99	5.05	100
Rockingham	7.0%	8.90	90	9.68	87	8.7%	6.34	92	6.89	89
Stokes	23.2%	31.61	7	31.63	6	34.3%	29.14	7	29.16	6
Surry	6.6%	6.91	98	7.52	99	8.1%	4.75	98	5.17	99
Yadkin	7.2%	7.96	93	8.48	93	9.7%	5.35	93	5.79	95
HSA III	17.7%	19.02		24.45		0.9%	17.16		22.05	
Cabarrus	7.4%	6.53	100	7.87	98	10.0%	4.44	100	5.35	98
Gaston	9.4%	10.50	80	11.81	72	12.9%	8.22	79	9.25	67
Iredell	10.6%	10.97	73	12.07	67	16.1%	8.61	75	9.48	64
Lincoln	13.2%	13.76	51	14.93	37	19.4%	11.68	48	12.67	35
Mecklenburg	28.2%	28.03	9	41.95	3	39.5%	26.51	8	39.67	3
Rowan	8.1%	7.02	97	8.09	97	11.5%	4.97	96	5.72	94
Stanly	2.7%	7.71	94	8.61	91	2.2%	5.09	95	5.69	96
Union	20.3%	21.37	17	24.58	14	30.1%	19.47	15	22.39	13
HSA IV	17.3%	20.86		26.55		0.8%	19.15		24.36	
Chatham	7.3%	10.40	82	11.66	74	8.5%	8.33	78	9.34	65
Durham	24.2%	33.12	6	44.39	2	32.7%	31.15	4	41.76	2
Franklin	7.4%	14.79	46	13.31	55	8.5%	12.02	43	10.81	49
Granville	9.4%	14.32	48	13.00	59	11.9%	11.75	47	10.67	52
Johnston	16.5%	34.40	4	32.72	5	22.5%	31.05	5	29.53	5
Lee	7.3%	9.88	86	11.81	71	8.6%	7.67	82	9.17	66
Orange	12.8%	12.40	66	16.09	31	15.4%	11.24	50	14.58	26
Person	8.0%	15.63	42	15.10	35	10.3%	12.00	44	11.59	42
Vance	7.3%	12.88	63	12.65	63	8.3%	10.54	57	10.35	55
Wake	22.2%	18.66	24	27.69	10	29.0%	17.56	18	26.06	10
Warren	12.4%	34.25	5	29.50	7	15.1%	30.87	6	26.60	7

COUNTY	PUBLIC INDIGENT-RELATED COSTS: County Share of Total	County Total/ $10000 Income	RANK	County Total/ Resident	RANK	EXCLUDING LONG-TERM CARE COSTS: County Share of Total	County Total/ $10000 Income	RANK	County Total/ Resident	RANK
HSA V	11.2%	18.13		17.31		0.6%	15.70		14.99	
Anson	6.1%	13.93	61	11.65	75	7.3%	8.51	76	7.66	81
Bladen	6.3%	15.81	40	12.74	62	7.0%	12.20	40	9.83	60
Brunswick	18.3%	28.12	8	24.77	13	24.4%	25.84	9	22.76	12
Columbus	9.8%	26.75	12	22.20	18	11.3%	23.65	12	19.63	18
Cumberland	9.0%	9.43	88	9.62	88	10.7%	8.01	80	8.18	76
Harnett	7.6%	15.61	43	13.36	53	9.2%	12.08	41	10.34	56
Hoke	6.5%	13.09	60	9.10	89	7.2%	10.58	56	7.36	84
Montgomery	6.6%	9.26	89	8.60	90	7.9%	6.66	90	6.33	92
Moore	7.1%	7.29	95	8.56	92	8.8%	5.20	94	6.11	93
New Hanover	15.1%	18.86	22	21.83	19	22.6%	16.38	23	18.96	19
Pender	51.1%	177.69	1	153.85	1	63.7%	174.19	1	150.83	1
Richmond	6.4%	10.57	78	9.74	86	7.2%	7.77	81	7.16	85
Robeson	7.7%	18.04	30	14.09	44	8.6%	15.31	27	11.96	36
Sampson	8.2%	15.67	41	14.62	42	10.1%	12.39	38	11.56	43
Scotland	6.4%	12.54	64	11.90	70	7.2%	9.58	62	9.09	70
HSA VI	10.2%	15.34		15.51		0.7%	12.53		12.66	
Beaufort	8.8%	12.09	68	12.29	66	12.7%	8.83	71	8.98	72
Bertie	13.7%	37.35	3	33.86	4	23.9%	34.08	3	30.89	4
Camden	9.4%	14.10	49	12.50	64	14.7%	10.48	58	9.29	66
Carteret	11.1%	12.88	62	12.38	65	17.1%	10.16	59	9.77	62
Chowan	9.7%	19.65	19	18.40	23	14.9%	14.79	31	13.85	30
Craven	12.9%	16.55	37	17.94	26	17.2%	14.30	32	15.50	25
Currituck	12.7%	10.83	76	9.65	85	20.1%	8.77	73	8.00	79
Dare	11.4%	11.74	69	10.81	78	19.0%	8.99	69	8.28	75
Duplin	13.4%	20.51	10	24.79	12	18.9%	23.66	11	21.32	16
Edgecombe	6.4%	16.38	54	16.33	54	8.2%	9.92	60	9.89	59
Gates	6.8%	10.83	83	10.07	81	6.8%	6.58	91	6.47	91
Greene	6.9%	12.27	67	12.00	69	8.1%	9.28	64	9.08	71
Halifax	7.4%	17.05	32	14.62	41	8.5%	13.65	34	11.71	39
Hertford	6.9%	12.52	65	11.78	73	8.1%	9.32	63	8.78	74
Hyde	7.5%	14.99	46	11.47	74	10.0%	12.05	42	8.15	77
Jones	7.0%	14.10	49	13.28	56	8.5%	10.80	55	9.72	63
Lenoir	12.3%	22.98	15	23.88	17	16.9%	19.18	16	20.34	17
Martin	14.7%	24.09	10	24.44	15	19.7%	21.40	14	21.77	15
Nash	9.9%	13.88	56	16.11	39	12.8%	11.03	52	13.38	32
Northampton	6.2%	17.07	31	12.82	61	7.2%	11.92	45	8.95	73
Onslow	10.7%	8.34	92	8.42	94	14.6%	6.87	88	6.93	88
Pamlico	7.2%	13.48	53	13.48	51	9.2%	9.12	66	9.13	69
Pasquotank	8.5%	13.15	57	13.87	47	11.5%	9.86	61	10.41	54
Perquimans	7.9%	16.70	36	15.35	34	11.0%	11.87	46	10.91	46
Pitt	12.5%	18.53	24	19.11	22	16.5%	16.06	24	16.56	23
Tyrrell	6.5%	13.12	58	14.67	40	7.8%	9.05	68	10.12	58
Washington	10.8%	16.77	28	19.56	20	13.3%	16.40	22	17.08	20
Wayne	9.9%	14.10	50	13.89	48	14.5%	10.92	54	10.76	50
Wilson	8.5%	11.05	72	12.95	60	10.6%	8.79	72	10.30	57

SOURCES: COUNTY SHARE OF TOTAL--equals total local (county/city) expenditures divided by total public indigent-related expenditures (see Table 1).

COUNTY TOTAL PER $10,000 INCOME--equals total local expenditures divided by total income times 10,000 (latter figure obtained by multiplying 1985 per capita by total population (see Table 1).

COUNTY TOTAL PER RESIDENT--equals total local expenditures divided by total population.

TRENDS IN PUBLIC INDIGENT-RELATED HEALTH EXPENDITURES

Trends in Indigent Health Care, North Carolina Memorial Hospital

Trends in County/City Direct Appropriations to Hospitals for Indigent Care, Hospital Operations, and Hospital-Based Services

Trends in Long Term Indebtedness of County Hospitals

Table 14

TRENDS IN INDIGENT HEALTH CARE
NORTH CAROLINA MEMORIAL HOSPITAL

COUNTY	DOLLAR AMOUNT OF WRITE-OFFS DUE TO INDIGENCY FY83 Total	FY85 Total	AVERAGE WRITE-OFF PER RESIDENT	RANK	INDIGENCY WRITE-OFFS AS PERCENT OF GROSS REVENUES FY83	FY85	PERCENT OF WRITE-OFFS DUE TO OUT-PATIENT CARE FY83	FY85
STATE TOTAL	13,688.0	16,715.1	$2.44		12.4%	13.2%	18.6%	17.7%
HSA I	221.0	249.0	0.22		7.3%	9.2%	10.9%	9.5%
Alexander	1.0	0.9	0.04	91	1.5%	1.8%	63.1%	38.6%
Allegheny	13.8	0.7	0.72	53	56.0%	2.0%	1.4%	2.2%
Ashe	0.7	14.0	0.31	66	0.6%	34.8%	100.0%	0.7%
Avery	0.1	0.5	0.02	95	0.2%	3.3%	100.0%	7.4%
Buncombe	33.2	73.5	0.32	65	6.8%	15.1%	4.5%	3.9%
Burke	26.8	28.3	0.33	63	10.1%	11.3%	5.7%	7.3%
Caldwell	24.0	43.7	0.49	56	6.8%	54.0%	7.0%	9.8%
Catawba	29.7	22.1	0.14	81	8.9%	1.8%	2.0%	50.0%
Cherokee	0.0	2.8	0.07	88	0.0%	7.1%	NA	20.5%
Clay	0.4	0.0	0.03	92	1.0%	0.0%	64.5%	NA
Cleveland	22.9	18.0	0.24	70	7.7%	5.4%	15.1%	16.9%
Graham	.0	0.0	.00	100	4.0%	0.0%	100.0%	NA
Haywood	3.4	5.9	0.10	85	7.7%	9.5%	12.6%	23.0%
Henderson	1.0	1.9	0.02	94	0.8%	1.6%	27.0%	54.7%
Jackson	5.5	0.2	0.10	84	12.6%	0.3%	15.8%	100.0%
Macon	0.1	0.1	0.01	98	1.1%	1.4%	100.0%	100.0%
Madison	0.2	4.5	0.14	82	0.4%	23.4%	100.0%	3.2%
McDowell	2.3	12.4	0.20	76	1.1%	17.5%	51.8%	3.1%
Mitchell	0.5	8.7	0.32	64	1.7%	61.5%	100.0%	0.0%
Polk	26.5	4.9	1.06	43	52.0%	11.2%	2.6%	24.5%
Rutherford	10.5	6.3	0.15	80	5.0%	2.1%	72.4%	49.0%
Swain	.0	0.2	0.01	97	.0%	1.7%	100.0%	100.0%
Transylvania	.0	1.2	0.02	93	0.1%	1.3%	100.0%	24.6%
Watauga	4.6	5.8	0.15	79	15.4%	29.8%	10.8%	0.0%
Wilkes	13.4	17.4	0.25	69	10.9%	4.0%	7.0%	6.8%
Yancey	0.3	.0	0.01	96	2.2%	0.7%	32.8%	0.0%
HSA II	2,455.0	3,401.9	2.51		12.8%	14.3%	24.7%	22.9%
Alamance	1,374.2	2,163.9	17.26	3	13.4%	16.7%	30.9%	24.8%
Caswell	277.8	311.2	13.19	5	18.4%	19.2%	14.7%	16.4%
Davidson	30.3	33.6	0.27	67	10.3%	5.6%	33.4%	33.6%
Davie	0.2	0.0	.00	99	2.2%	0.0%	-15.9%	NA
Forsyth	25.6	44.2	0.14	83	15.9%	19.3%	19.6%	5.5%
Guilford	315.9	360.8	1.03	45	10.6%	10.5%	14.7%	24.3%
Randolph	305.2	287.2	3.05	19	10.6%	8.7%	18.9%	21.6%
Rockingham	112.1	175.9	1.67	36	11.0%	13.1%	15.4%	14.2%
Stokes	5.7	0.5	0.09	86	55.7%	4.1%	2.5%	6.0%
Surry	22.1	17.5	0.16	78	2.3%	10.9%	4.9%	22.9%
Yadkin	5.8	7.2	0.22	71	13.4%	11.6%	61.9%	45.0%
HSA III	185.9	334.4	0.24		9.3%	13.6%	13.7%	9.9%
Cabarrus	14.5	23.2	0.20	75	9.3%	15.2%	12.5%	3.3%
Gaston	88.9	44.5	0.39	59	15.0%	5.2%	14.4%	36.6%
Iredell	2.3	6.3	0.05	90	1.5%	7.4%	44.8%	30.1%
Lincoln	5.8	0.5	0.07	87	5.9%	0.3%	0.9%	47.0%
Mecklenburg	45.5	146.1	0.22	72	8.9%	26.1%	10.3%	3.1%
Rowan	13.0	39.2	0.25	68	5.2%	12.6%	18.2%	8.0%
Stanly	8.4	25.8	0.34	61	5.9%	10.4%	14.4%	17.4%
Union	7.5	48.9	0.36	60	7.0%	48.4%	18.3%	3.1%
HSA IV	5,966.3	7,124.0	7.38		13.2%	13.4%	20.7%	20.1%
Chatham	869.4	1,128.8	28.31	1	12.5%	14.0%	22.7%	22.1%
Durham	327.5	327.1	2.03	29	10.5%	10.2%	26.4%	21.1%
Franklin	153.3	168.9	5.03	14	22.0%	29.6%	11.2%	4.4%
Granville	117.1	107.4	3.04	20	22.7%	18.0%	9.4%	14.3%
Johnston	769.5	885.0	11.04	7	23.1%	22.6%	14.2%	16.1%
Lee	574.3	743.0	16.59	4	12.3%	13.7%	20.8%	20.0%
Orange	2,124.1	2,171.1	26.26	2	12.4%	10.5%	23.1%	25.5%
Person	283.8	295.0	8.68	9	19.5%	21.2%	19.3%	21.1%
Vance	193.6	137.7	4.33	16	11.9%	8.0%	18.5%	24.1%
Wake	525.5	1,049.2	2.31	27	9.7%	15.0%	21.0%	12.1%
Warren	78.4	110.9	5.85	11	16.1%	19.4%	17.3%	11.1%

COUNTY	DOLLAR AMOUNT OF WRITE-OFFS DUE TO INDIGENCY FY83 Total	FY85 Total	AVERAGE WRITE-OFF PER RESIDENT	RANK	INDIGENCY WRITE-OFFS AS PERCENT OF GROSS REVENUES FY83	FY85	PERCENT OF WRITE-OFFS DUE TO OUTPATIENT CARE FY83	FY85
HSA V	3,255.3	3,885.2	3.77		13.6%	13.9%	13.6%	12.9%
Anson	234.0	75.4	5.83	13	49.3%	20.6%	1.6%	8.8%
Bladen	72.6	40.5	1.83	33	5.7%	3.0%	28.9%	38.5%
Brunswick	65.0	44.6	1.24	40	11.1%	8.0%	4.5%	12.3%
Columbus	153.3	332.7	4.66	15	10.3%	13.8%	18.9%	7.3%
Cumberland	435.0	584.8	2.00	31	9.6%	12.0%	15.8%	13.9%
Harnett	700.7	666.1	10.81	8	18.6%	15.2%	18.1%	18.9%
Hoke	35.7	42.5	1.71	34	11.8%	9.4%	7.6%	8.0%
Montgomery	24.3	111.7	2.85	24	3.9%	13.9%	36.7%	20.6%
Moore	140.4	189.9	3.02	21	10.5%	10.4%	17.8%	18.6%
New Hanover	154.9	191.5	1.54	39	8.6%	13.8%	3.2%	8.3%
Pender	78.9	203.2	5.85	12	16.3%	18.4%	7.7%	1.0%
Richmond	298.9	356.6	7.26	10	17.8%	17.1%	11.9%	7.6%
Robeson	281.9	344.3	2.92	22	14.2%	12.9%	11.3%	14.2%
Sampson	450.9	688.0	11.25	6	15.8%	19.3%	11.4%	10.2%
Scotland	128.9	10.2	2.03	30	18.4%	9.1%	18.0%	194.7%
HSA VI	1,604.6	1,720.5	1.52		9.6%	10.0%	13.1%	10.5%
Beaufort	44.6	19.3	0.74	51	10.4%	3.2%	6.0%	12.9%
Bertie	42.0	6.2	1.12	41	23.3%	2.7%	7.3%	36.7%
Camden	0.7	1.7	0.21	74	2.5%	4.4%	0.1%	1.9%
Carteret	51.0	18.8	0.72	52	11.1%	4.8%	12.9%	11.3%
Chowan	7.7	6.5	0.56	54	12.7%	5.7%	97.5%	47.1%
Craven	67.9	46.3	0.74	50	7.0%	5.8%	7.4%	5.0%
Currituck	3.3	8.6	0.44	58	20.6%	29.2%	83.2%	26.4%
Dare	5.2	1.6	0.21	73	9.7%	7.5%	6.1%	91.7%
Duplin	144.4	149.9	3.55	18	12.1%	10.0%	14.1%	11.5%
Edgecombe	74.5	186.5	2.24	28	6.1%	11.4%	29.9%	10.3%
Gates	16.9	2.1	1.03	44	27.8%	7.2%	10.7%	34.6%
Greene	32.9	1.5	1.02	46	12.4%	0.3%	10.3%	53.1%
Halifax	167.7	186.8	2.89	23	10.4%	12.4%	10.4%	14.6%
Hertford	52.2	42.0	1.99	32	15.4%	16.4%	14.3%	17.5%
Hyde	6.1	0.2	0.53	55	6.0%	0.8%	11.4%	100.0%
Jones	28.7	4.1	1.66	37	16.3%	1.1%	3.7%	53.7%
Lenoir	278.7	174.8	3.70	17	16.2%	14.5%	10.7%	13.4%
Martin	13.7	39.2	1.00	47	10.2%	15.4%	22.5%	13.0%
Nash	110.7	286.0	2.80	25	8.9%	18.7%	12.1%	4.0%
Northampton	23.0	25.9	1.10	42	5.7%	5.9%	25.9%	16.2%
Onslow	177.5	211.5	1.60	38	7.3%	11.8%	6.2%	3.3%
Pamlico	1.5	0.0	0.07	89	0.9%	0.0%	108.1%	NA
Pasquotank	11.8	39.1	0.88	48	7.6%	14.0%	31.6%	7.4%
Perquimans	0.3	8.8	0.46	57	0.3%	9.8%	77.9%	15.3%
Pitt	61.2	5.3	0.34	62	8.7%	0.9%	10.0%	36.9%
Tyrrell	.0	1.5	0.19	77	0.1%	15.2%	100.0%	65.6%
Washington	17.1	55.0	2.47	26	6.4%	47.8%	3.9%	2.1%
Wayne	100.2	61.4	0.81	49	6.6%	3.4%	25.1%	31.5%
Wilson	93.2	128.5	1.70	35	8.9%	16.5%	10.7%	8.5%

SOURCES: North Carolina Memorial Hospital, **North Carolina Memorial Hospital Indigency by County for the Year Ending June 30, 1985** and **The North Carolina Memorial Hospital Indigency Write-offs by County, Fiscal Years 1982/83 and 1981/82.**

DOLLAR AMOUNT OF INDIGENCY WRITE-OFFS DUE TO INDIGENCY--includes all charges written off to charity care. Figures do not include bad debts or contractual allowances due to Medicaid, Medicare or other public patients. Totals include both inpatient and outpatient write-offs.

AVERAGE WRITE-OFF PER RESIDENT--total indigency write-offs divided by total county population.

INDIGENCY WRITE-OFFS AS PERCENT OF GROSS REVENUES--gross revenues represent the total amount of patient revenue the hospital would have received if all patients had paid full charges. Charity write-offs as a percent of gross revenues basically represent the fraction of all charges which are written off to charity.

PERCENT OF WRITE-OFFS DUE TO OUTPATIENT CARE--shows the fraction of indigency write-offs which are attributable to amounts written off for outpatient care.

Table 15

TRENDS IN COUNTY/CITY DIRECT APPROPRIATIONS TO HOSPITALS
FOR INDIGENT CARE, HOSPITAL OPERATIONS AND HOSPITAL-BASED SERVICES
(All Figures in Thousands)

COUNTY	COUNTY ROLE: Own Hospital?	COUNTY ROLE: Operate Hospital?	TOTAL COUNTY/CITY DIRECT PAYMENTS TO HOSPITALS: 1984 Actual	1985 Actual	1986 Budget	RANKING: 1984	1985	1986	PERCENT CHANGE 1984-1986	RANK
STATE TOTAL			$14,784	$16,845	$19,178				129.7%	
HSA I			805	799	794				98.6%	
Alexander	No	No	0	0	0	31	97	82	0.0%	30
Allegheny	No	No	0	0	0	29	57	85	0.0%	28
Ashe	No	No	0	0	0	91	70	29	0.0%	69
Avery	No	No	0	0	0	78	44	45	0.0%	95
Buncombe	No	No	754	754	754	4	4	4	99.9%	10
Burke	No	No	0	0	0	80	48	49	0.0%	96
Caldwell	No	No	0	0	0	62	63	96	0.0%	87
Catawba	Yes	Yes	0	0	0	58	59	94	0.0%	85
Cherokee	No	No	0	0	0	76	40	41	0.0%	94
Clay	No	No	1	0	0	26	28	27	20.0%	25
Cleveland	Yes	No	0	0	0	92	72	32	0.0%	55
Graham	No	No	0	0	0	95	78	44	0.0%	43
Haywood	Yes	Yes	0	0	0	99	86	60	0.0%	39
Henderson	Yes	Yes	0	0	0	38	39	99	0.0%	75
Jackson	No	No	5	5	5	22	25	24	83.3%	19
Macon	No	No	0	0	0	97	82	52	0.0%	31
Madison	No	No	0	0	0	30	31	97	0.0%	71
McDowell	No	No	0	0	0	71	30	31	0.0%	29
Mitchell	No	No	0	0	0	70	71	30	0.0%	91
Polk	Yes	No	0	0	0	53	83	54	0.0%	52
Rutherford	No	No	26	19	15	18	22	22	56.2%	23
Swain	No	No	0	0	0	28	52	53	0.0%	70
Transylvania	No	No	0	0	0	32	33	73	0.0%	72
Watauga	Yes	No	0	0	0	52	53	83	0.0%	82
Wilkes	City	City	20	20	20	19	21	19	95.2%	16
Yancey	No	No	0	0	0	85	58	59	0.0%	57
HSA II			346	552	495				142.5%	
Alamance	Yes	No	0	0	0	33	73	34	0.0%	32
Caswell	No	No	0	0	0	94	76	40	0.0%	59
Davidson	No	No	0	0	0	51	90	68	0.0%	50
Davie	Yes	Yes	0	0	0	81	50	51	0.0%	49
Forsyth	Yes	No	0	0	0	98	84	56	0.0%	47
Guilford	No	No	205	205	205	6	12	9	99.5%	11
Randolph	No	No	0	0	0	55	92	72	0.0%	54
Rockingham	No	No	0	0	0	61	87	62	0.0%	60
Stokes	Yes	Yes	101	307	250	11	7	8	244.2%	5
Surry	Dist	Dist	0	0	0	69	91	70	0.0%	68
Yadkin	Yes	Yes	40	40	40	15	17	16	97.6%	13
HSA III			6,449	6,784	8,374				129.8%	
Cabarrus	Yes	No	0	0	0	96	80	48	0.0%	63
Gaston	Yes	No	0	0	0	79	46	47	0.0%	45
Iredell	Yes	No	0	0	0	93	74	36	0.0%	35
Lincoln	Yes	No	1	1	3	25	27	25	111.0%	9
Mecklenburg	Yes	No	6,448	6,783	8,371	1	1	1	129.8%	7
Rowan	No	No	0	0	0	63	96	80	0.0%	62
Stanly	No	No	0	0	0	67	100	88	0.0%	66
Union	Yes	No	0	0	0	44	45	79	0.0%	78
HSA IV			6,043	6,825	7,972				131.9%	
Chatham	No	No	0	0	0	84	56	28	0.0%	26
Durham	Yes	No	1,958	2,512	2,862	3	3	3	146.1%	6
Franklin	Yes	Yes	0	0	0	46	47	98	0.0%	79
Granville	Yes	Yes	60	72	571	13	15	5	936.7%	1
Johnston	Yes	Yes	0	100	100	86	14	14	NA	99
Lee	No	No	0	0	0	73	34	35	0.0%	33
Orange	No	No	0	0	0	41	77	42	0.0%	40
Person	No	No	58	35	35	14	19	17	59.8%	22
Vance	No	No	4	2	1	23	26	26	25.1%	24
Wake	Yes*	Yes*	3,846	3,854	4,320	2	2	2	112.3%	8
Warren	Yes	Yes	117	251	82	10	9	15	69.4%	21

COUNTY	COUNTY ROLE: Own Hospital?	COUNTY ROLE: Operate Hospital?	TOTAL COUNTY/CITY DIRECT PAYMENTS TO HOSPITALS: 1984 Actual	1985 Actual	1986 Budget	RANKING 1984	RANKING 1985	RANKING 1986	PERCENT CHANGE 1984-1986	RANK
HSA V			203	455	314				153.7%	
Anson	Yes	No	0	0	0	57	85	58	0.0%	27
Bladen	Yes	Yes	0	0	0	66	67	100	0.0%	69
Brunswick**	Twnshp	Twnshp	162	162	162	8	13	10	99.4%	12
Columbus	Yes	No	0	0	0	54	55	92	0.0%	65
Cumberland	Yes	Yes	0	0	0	72	32	33	0.0%	95
Harnett***	City	No	8	8	8	21	24	23	88.9%	18
Hoke	No	No	0	0	0	75	38	39	0.0%	37
Montgomery	No	No	0	0	0	60	61	87	0.0%	66
Moore	No	No	0	0	0	89	66	67	0.0%	65
New Hanover	Yes	No	0	0	0	37	75	38	0.0%	36
Pender	Yes	No	30	275	125	17	8	12	403.2%	3
Richmond	Yes	No	0	0	0	27	60	61	0.0%	56
Robeson	Yes	No	0	0	0	59	94	76	0.0%	58
Sampson	Yes	No	3	10	19	24	23	21	441.9%	2
Scotland	No	No	0	0	0	65	89	66	0.0%	64
HSA VI			937	1,431	1,229				131.0%	
Beaufort	Yes	No	0	0	0	100	88	64	0.0%	67
Bertie	Yes	Yes	186	492	465	7	5	6	248.2%	4
Camden	No	No	0	0	0	87	62	63	0.0%	61
Carteret	Yes	No	70	70	0	12	16	57	0.0%	98
Chowan	Yes	No	0	0	114	88	64	13	NA	100
Craven	Yes	No	0	0	0	83	54	55	0.0%	53
Currituck	No	No	0	0	0	90	68	69	0.0%	51
Dare	No	No	0	0	0	50	51	90	0.0%	81
Duplin	Yes	No	153	214	150	9	11	11	97.5%	14
Edgecombe	No	No	0	0	0	68	69	91	0.0%	90
Gates	No	No	0	0	0	64	65	89	0.0%	88
Greene	No	No	0	0	0	42	43	95	0.0%	77
Halifax	Dist	No	0	0	0	77	42	43	0.0%	41
Hertford	No	No	20	20	20	20	20	20	95.2%	15
Hyde	No	No	0	0	0	74	36	37	0.0%	93
Jones	No	No	0	0	0	34	35	93	0.0%	73
Lenoir	Yes	No	0	250	0	82	10	65	0.0%	97
Martin	Yes	Yes	472	349	450	5	6	7	95.1%	17
Nash	Yes	No	0	0	0	35	93	74	0.0%	34
Northampton	No	No	0	0	0	47	98	84	0.0%	46
Onslow	Yes	Auth	0	0	0	39	99	86	0.0%	38
Pamlico	No	No	0	0	0	43	95	78	0.0%	42
Pasquotank	Yes	Yes	0	0	0	36	37	75	0.0%	74
Perquimans	No	No	0	0	0	45	79	46	0.0%	44
Pitt	Yes	No	0	0	0	49	81	50	0.0%	48
Tyrrell	No	No	0	0	0	40	41	77	0.0%	76
Washington	Yes	No	0	0	0	48	49	81	0.0%	80
Wayne	Yes	Yes	0	0	0	56	29	71	0.0%	99
Wilson	Yes	No	36	36	30	16	18	18	81.1%	21

SOURCES: COUNTY ROLE--indicates whether the county owns or operates any general acute-care hospitals (some counties own more than one). "Dist" denotes hospital districts; "city" denotes cities; "twnshp" denotes townships; "auth" denotes hospitals owned by specially-created hospital authorities. In cases where the county owns a facility, but does not operate it, the facility is operated by either a for-profit or non-profit corporation unless otherwise indicated. This information is current as of October, 1985. Data obtained from N.C. Department of Human Resources, Division of Facility Services.

TOTAL COUNTY/CITY DIRECT PAYMENTS TO HOSPITALS--includes all county appropriations to hospitals for care of indigent patients. In some cases, figures include operating subsidies for certain services (e.g., ambulance) which may benefit the general public rather than just indigent patients. Unpublished data compiled in 1986 by Local Government Commission.

* Wake County owns 4 general hospitals, which are operated by non-profit corporations. However, the county operates a fifth facility which is own by a non-profit corporation.

** Includes operating subsidies paid to J. Arthur Dosher Memorial Hospital, a township-owned facility in Southport. These payments are made from a tax levied by Smithfield Township.

*** Includes operating subsidies paid to Betsy Johnson Memorial Hospital, a city-owned facility in Dunn. These payments are made from taxes levied by the city of Dunn.

TRENDS IN LONG TERM INDEBTEDNESS OF COUNTY HOSPITALS
(All Figures in Thousands)

COUNTY	OUTSTANDING HOSPITAL LONG TERM DEBTS, 6/30/85 G.O. Bonds	Revenue Bonds	Lease/ Purchase	ANNUALIZED DEBT PAYMENTS FOR LONG TERM DEBTS/LEASES FY1985	FY1986	SHARE OF DEBT PAID FROM COUNTY FUNDS 1985	1986
STATE TOTAL	123,469	90,988	3,011	33,140	28,810	46.5%	60.3%
HSA I	17,569	6,875	0	2,990	2,962	40.4%	35.2%
Alexander	0	0	0	0	0	NA	NA
Allegheny	0	0	0	0	0	NA	NA
Ashe	0	0	0	0	0	NA	NA
Avery	0	0	0	0	0	NA	NA
Buncombe	0	0	0	0	0	NA	NA
Burke	0	0	0	0	0	NA	NA
Caldwell	0	0	0	0	0	NA	NA
Catawba*	375	2,235	0	575	664	53.8%	45.3%
Cherokee	0	0	0	0	0	NA	NA
Clay	0	0	0	0	0	NA	NA
Cleveland*	90	4,640	0	474	410	50.6%	22.7%
Graham	0	0	0	0	0	NA	NA
Haywood*	10,400	0	0	1,281	1,238	0.0%	0.0%
Henderson*	1,344	0	0	210	206	100.0%	100.0%
Jackson	0	0	0	0	0	NA	NA
Macon	0	0	0	0	0	NA	NA
Madison	0	0	0	0	0	NA	NA
McDowell	0	0	0	0	0	NA	NA
Mitchell	0	0	0	0	0	NA	NA
Polk*	515	0	0	90	87	100.0%	100.0%
Rutherford	0	0	0	0	0	NA	NA
Swain	0	0	0	0	0	NA	NA
Transylvania	0	0	0	0	0	NA	NA
Watauga*	4,720	0	0	317	317	100.0%	100.0%
Wilkes**	125	0	0	42	41	100.0%	100.0%
Yancey	0	0	0	0	0	NA	NA
HSA II	2,025	0	0	310	302	66.5%	82.9%
Alamance*	All Debts Paid		0	0	0	NA	NA
Caswell	0	0	0	0	0	NA	NA
Davidson	0	0	0	0	0	NA	NA
Davie*	425	0	0	73	71	0.0%	70.5%
Forsyth*	All Debts Paid		0	0	0	NA	NA
Guilford	0	0	0	0	0	NA	NA
Randolph	0	0	0	0	0	NA	NA
Rockingham	0	0	0	0	0	NA	NA
Stokes*	1,600	0	0	206	201	100.0%	100.0%
Surry**	0	0	0	0	0	NA	NA
Yadkin*	0	0	0	31	31	0.0%	0.0%
HSA III	25,480	18,200	0	6,161	4,932	46.5%	45.8%
Cabarrus*	0	0	0	0	0	NA	NA
Gaston*	All Debts Paid		0	0	0	NA	NA
Iredell*	1,025	15,935	0	2,109	2,090	12.1%	11.8%
Lincoln*	50	2,265	0	220	215	0.0%	24.2%
Mecklenburg*	12,655	0	0	1,299	1,286	100.0%	100.0%
Rowan	0	0	0	0	0	NA	NA
Stanly	0	0	0	0	0	NA	NA
Union*	11,750	0	0	2,533	1,340	51.7%	50.4%
HSA IV	22,505	34,635	3,011	10,741	9,265	27.5%	97.0%
Chatham	0	0	0	0	0	NA	NA
Durham*	13,450	0	0	1,785	1,730	100.0%	100.0%
Franklin*	55	0	0	18	17	100.0%	100.0%
Granville*	2,800	0	0	0	387	NA	50.0%
Johnston*	6,200	0	0	1,207	1,162	93.2%	93.0%
Lee	0	0	0	25	0	100.0%	NA
Orange	0	0	0	0	0	NA	NA
Person	0	0	0	0	0	NA	NA
Vance	0	0	0	0	0	NA	NA
Wake*	0	34,635	3,011	7,707	5,969	0.0%	100.0%
Warren*	0	0	0	0	0	NA	NA

COUNTY	OUTSTANDING HOSPITAL LONG TERM DEBTS, 6/30/85 G.O. Bonds	Revenue Bonds	Lease/ Purchase	ANNUALIZED DEBT PAYMENTS FOR LONG TERM DEBTS/LEASES FY1985	FY1986	SHARE OF DEBT PAID FROM COUNTY FUNDS 1985	1986
HSA V	30,055	3,323	0	7,152	4,214	73.3%	55.6%
Anson*	195	0	0	60	58	0.0%	0.0%
Bladen*	0	0	0	0	0	NA	NA
Brunswick***	1,825	0	0	504	499	100.0%	100.0%
Columbus*	4,400	0	0	560	567	82.1%	82.4%
Cumberland*	7,100	0	0	842	822	0.0%	0.0%
Harnett****	0	0	0	6	6	NA	NA
Hoke	0	0	0	0	0	NA	NA
Montgomery	0	0	0	0	0	NA	NA
Moore	0	0	0	0	0	NA	NA
New Hanover*	7,860	0	0	1,102	1,067	100.0%	100.0%
Pender*	3,000	0	0	3,171	306	100.0%	100.0%
Richmond*	5,675	0	0	638	621	0.0%	0.0%
Robeson*	0	0	0	0	0	NA	NA
Sampson*	0	3,323	0	268	267	0.0%	0.0%
Scotland	0	0	0	0	0	NA	NA
HSA VI	25,835	27,955	0	5,786	7,136	50.9%	34.7%
Beaufort*	50	0	0	54	52	100.0%	100.0%
Bertie*	0	0	0	0	0	NA	NA
Camden	0	0	0	0	0	NA	NA
Carteret*	5,915	0	0	553	701	8.5%	6.5%
Chowan*	300	2,490	0	271	631	30.1%	12.4%
Craven*	3,775	0	0	524	533	100.0%	100.0%
Currituck	0	0	0	0	0	NA	NA
Dare	0	0	0	0	0	NA	NA
Duplin*	450	0	0	99	96	100.0%	100.0%
Edgecombe	50	0	0	54	52	0.0%	0.0%
Gates	0	0	0	0	0	NA	NA
Greene	0	0	0	0	0	NA	NA
Halifax***	260	0	0	274	260	0.0%	0.0%
Hertford	0	0	0	0	0	NA	NA
Hyde	0	0	0	0	0	NA	NA
Jones	0	0	0	0	0	NA	NA
Lenoir*	3,025	21,025	0	1,796	2,705	20.9%	13.9%
Martin*	0	0	0	0	0	NA	NA
Nash*	1,980	3,000	0	538	529	57.2%	56.4%
Northampton	0	0	0	0	0	NA	NA
Onslow*	1,625	0	0	252	242	100.0%	100.0%
Pamlico	0	0	0	0	0	NA	NA
Pasquotank*	0	0	0	0	0	NA	NA
Perquimans	0	0	0	0	0	NA	NA
Pitt*	5,350	1,440	0	843	818	80.2%	79.5%
Tyrrell	0	0	0	0	0	NA	NA
Washington*	575	0	0	109	105	100.0%	100.0%
Wayne*	2,480	0	0	421	413	100.0%	0.0%
Wilson*	0	0	0	0	0	NA	NA

SOURCES: All figures are from unpublished data compiled in 1986 by the Local Government Commission.

OUTSTANDING HOSPITAL LONG TERM DEBTS--total amount of long term hospital debts as of July 30, 1985. Figures include general obligation (G.O.) bonds, revenue bonds, and lease/purchase agreements for hospital operations. "Paid" denotes counties in which all outstanding long term debts were completely paid up as of the date shown.

ANNUALIZED DEBT PAYMENTS--total payments made for hospital debt during the fiscal years shown (including principal and interest). Totals include amounts paid by counties as well as amounts paid directly by hospitals through patient revenues or other revenue sources.

SHARE OF DEBT PAID FROM COUNTY FUNDS--total amount of annualized debt payments which were paid through county appropriations in the fiscal years shown. Except in Edgecombe County, all debt payments not made by the county were financed through hospital revenues.

* Denotes counties which own at least 1 general hospital.

** Denotes counties where a city or district owns a general hospital.

*** Includes debt service paid by Smithfield Township for Arthur J. Dosher Memorial Hospital. However, the amount of outstanding long term debt for this hospital is **not** included in the totals.

**** Includes debt service paid by city of Dunn for Betsy Johnson Memorial Hospital. However, the amount of outstanding long term debt for this hospital is **not** included in the totals.

SOURCES OF REVENUE FOR PUBLIC INDIGENT-RELATED HEALTH EXPENDITURES

County/City Funding for Indigent-Related Health Care, FY85

State and Federal Funding for Indigent-Related Health Care, FY85

Expenditures for Public Medical Programs, FY85

Expenditures for Area Mental Health Programs, FY85

Table 17

COUNTY/CITY FUNDING FOR INDIGENT-RELATED HEALTH CARE, FY85
(All Figures in Thousands)

COUNTY	*	COUNTY/CITY APPROPRIATIONS: Medicaid	Public Programs	Area Mental Health	Hospital Direct	Hospital Debts	COUNTY/CITY TOTAL	EXCLUDE LONG-TERM CARE**	RANK
STATE TOTAL		$29,159	$7,366	$50,735	$16,845	$15,420	$119,524	$104,090	
HSA I		4,579	913	7,353	799	1,209	14,853	12,052	
Alexander	M	93	74	157	0	0	324	264	70
Allegheny	MD	32	11	109	0	0	151	138	86
Ashe	MD	96	25	256	0	0	376	336	59
Avery	MD	71	0	164	0	0	235	197	78
Buncombe	M	666	77	741	754	0	2,238	1,795	11
Burke	M	305	6	442	0	0	753	535	46
Caldwell	M	301	0	401	0	0	703	524	47
Catawba		448	99	619	0	309	1,475	1,190	20
Cherokee	M	104	1	192	0	0	297	236	72
Clay	M	44	7	68	0	0	119	95	95
Cleveland		429	273	514	0	240	1,456	1,194	17
Graham	M	38	0	67	0	0	106	85	96
Haywood	M	216	0	451	0	0	667	555	45
Henderson	M	232	75	356	0	210	873	718	32
Jackson	M	111	0	262	5	0	378	308	65
Macon	M	60	149	223	0	0	432	398	52
Madison	M	102	56	76	0	0	234	185	79
McDowell	MD	179	0	216	0	0	395	275	69
Mitchell	MD	78	0	63	0	0	141	101	92
Polk	MD	48	0	128	0	90	266	231	73
Rutherford	MD	273	0	496	19	0	788	629	37
Swain	M	53	1	104	0	0	158	131	88
Transylvania	M	119	24	136	0	0	279	204	75
Watauga	MD	106	37	380	0	317	839	775	31
Wilkes	M	316	1	663	20	42	1,042	850	28
Yancey	MD	60	0	69	0	0	128	103	91
HSA II		4,966	3,430	12,595	552	206	21,750	18,921	
Alamance	M	386	123	2,420	0	0	2,929	2,688	7
Caswell	MD	107	0	527	0	0	634	588	40
Davidson		445	9	718	0	0	1,171	910	26
Davie	M	116	0	116	0	0	232	154	83
Forsyth	M	1,204	898	2,898	0	0	5,000	4,392	5
Guilford		1,410	2,313	4,471	205	0	8,398	7,582	3
Randolph		323	0	392	0	0	716	491	49
Rockingham		447	0	389	0	0	836	595	38
Stokes	M	154	59	399	307	206	1,126	1,038	22
Surry	M	249	28	177	0	0	455	313	63
Yadkin	M	125	0	87	40	0	252	169	81
HSA III		4,366	278	11,718	6,784	2,864	26,010	23,457	
Cabarrus	M	368	0	366	0	0	733	498	48
Gaston	M	763	0	1,248	0	0	2,011	1,575	14
Iredell	M	373	58	361	0	256	1,048	823	30
Lincoln	M	169	171	328	1	0	669	568	44
Mecklenburg		1,801	0	8,485	6,783	1,299	18,368	17,372	1
Rowan	M	392	13	428	0	0	834	590	39
Stanly	M	206	26	195	0	0	427	282	68
Union	M	294	10	307	0	1,310	1,920	1,749	12
HSA IV		3,987	1,854	7,922	6,825	2,953	23,541	21,603	
Chatham	MD	150	0	261	0	0	412	330	61
Durham		886	260	1,701	2,512	1,785	7,144	6,720	4
Franklin	M	203	0	206	0	18	427	347	58
Granville	MD	171	0	237	72	0	480	394	54
Johnston		443	2	781	100	1,125	2,451	2,212	8
Lee	MD	209	0	235	0	25	469	364	56
Orange	M	229	481	605	0	0	1,315	1,192	18
Person	MD	200	0	226	35	0	460	353	57
Vance	MD	236	0	246	2	0	484	396	53
Wake		1,138	1,111	3,320	3,854	0	9,422	8,865	2
Warren	M	123	0	104	251	0	477	430	51

COUNTY	*	COUNTY/CITY APPROPRIATIONS: Medicaid	Public Programs	Area Mental Health	Hospital Direct	Hospital Debts	COUNTY/CITY TOTAL	EXCLUDE LONG-TERM CARE**	RANK
HSA V		5,116	550	5,047	455	5,244	16,412	14,209	
Anson	M	192	8	110	0	0	309	203	76
Bladen	M	230	0	164	0	0	394	304	66
Brunswick	M	199	4	227	162	504	1,096	1,007	24
Columbus	M	421	0	276	0	460	1,156	1,022	23
Cumberland		1,028	0	1,429	0	0	2,457	2,089	10
Harnett	M	401	56	374	8	6	845	654	36
Hoke	M	114	0	94	0	0	208	168	82
Montgomery	M	110	2	98	0	0	210	151	85
Moore	M	225	18	226	0	0	468	334	60
New Hanover	M	565	214	576	0	1,102	2,458	2,135	9
Pender	M	140	0	123	275	3,171	3,710	3,637	6
Richmond	M	247	7	187	0	0	442	325	62
Robeson	M	702	241	567	0	0	1,511	1,283	15
Sampson	M	315	0	416	10	0	740	585	41
Scotland	M	226	0	181	0	0	407	311	64
HSA VI		6,145	340	6,099	1,431	2,944	16,960	13,850	
Beaufort	M	230	1	246	0	54	531	388	55
Bertie	M	141	2	96	492	0	731	667	34
Camden	MD	26	4	43	0	0	74	55	98
Carteret	M	199	5	276	70	47	596	470	50
Chowan	MD	90	9	58	0	82	238	179	80
Craven	M	380	36	441	0	524	1,380	1,192	19
Currituck	M	34	0	99	0	0	133	108	89
Dare	M	56	1	122	0	0	179	137	87
Duplin	M	269	107	341	214	99	1,028	884	27
Edgecombe	M	438	0	340	0	0	778	577	43
Gates	MD	52	0	41	0	0	92	59	97
Greene	M	116	7	79	0	0	201	152	84
Halifax		416	0	407	0	0	822	658	35
Hertford	MD	156	0	107	20	0	282	210	74
Hyde	M	34	1	34	0	0	69	49	99
Jones	M	74	0	56	0	0	131	96	94
Lenoir		440	0	398	250	375	1,463	1,246	16
Martin	MD	149	0	152	349	0	649	578	42
Nash	M	417	4	413	0	308	1,142	949	25
Northampton	M	181	5	99	0	0	285	199	77
Onslow		335	3	437	0	252	1,027	845	29
Pamlico	M	84	0	62	0	0	145	98	93
Pasquotank	MD	169	19	212	0	0	401	301	67
Perquimans	MD	73	7	73	0	0	152	108	90
Pitt		536	0	645	0	676	1,856	1,609	13
Tyrrell	MD	37	0	24	0	0	61	42	100
Washington	MD	93	0	83	0	109	285	249	71
Wayne		541	7	411	0	421	1,379	1,068	21
Wilson	M	380	124	306	36	0	846	673	33

SOURCES: MEDICAID--total county outlays for all Medicaid services (including long term care) during federal FY85. Unpublished data obtained from Division of Medical Assistance.

PUBLIC PROGRAMS--includes county outlays in state FY85 for the following direct service delivery programs: tuberculosis control, venereal disease control, adult health, kidney disease, home health, migrant/refugee health, sickle cell and genetic diseases, maternal and child health, immunizations, family planning, crippled childrens' services, and dental services. Figures generally include amounts spent by local health departments and exclude direct purchase-of-care arrangements with providers (e.g., for kidney dialysis, inpatient care, pharmaceuticals, etc.). In counties which are part of district health departments, total funding has been estimated by apportioning each district department's total outlays among counties based on their share of total population within their respective district. See Table 19 for details. Unpublished data obtained from Division of Health Services.

MENTAL HEALTH--estimated county outlays for all area mental health programs during state FY85. In counties which are part of multi-county area mental health programs, total funding has been estimated by apportioning each area program's total outlays among counties based on their share of total population within their respective area program. See Table 20 for details. Unpublished data obtained from Division of Mental Health, Mental Retardation and Substance Abuse Services.

HOSPITAL DIRECT--actual county or city payments to hospitals for patient care in FY85. See Table 10 for details.

HOSPITAL DEBTS--actual county or city payments to or on behalf of hospitals for repayment of long term debt (including principal and interest. See Table 16 for details.

* M denotes counties which are part of multi-county area mental health programs. D denotes counties in district health departments. In both cases, total funds per county for these respective programs have been estimated based on each county's share of population. See Table 19 for a list of district health departments and Table 20 for a list of area mental health programs

** See Table 12 for explanation of what is included in long-term care.

Table 18

STATE AND FEDERAL FUNDING FOR INDIGENT-RELATED HEALTH CARE, FY85
(All Figures in Thousands)

COUNTY	*	STATE REVENUES				FEDERAL REVENUES			STATE & FEDERAL TOTAL**
		Medicaid	Public Programs	Area Mental Health	N.C. Memorial	Medicaid	Public Programs	Area Mental Health	
STATE TOTAL		175,339	13,602	93,949	16,715	430,296	9,187	17,092	760,036
HSA I		26,091	2,491	14,162	249	68,017	1,460	3,850	116,800
Alexander	M	533	52	340	1	1,378	46	44	2,397
Allegheny	MD	186	42	164	1	481	25	53	957
Ashe	MD	549	98	385	14	1,427	58	123	2,668
Avery	MD	400	73	247	0	1,044	38	79	1,889
Buncombe	M	3,790	336	1,934	74	9,850	163	234	16,461
Burke	M	1,735	87	955	23	4,507	63	124	7,507
Caldwell	M	1,720	207	866	44	4,478	101	113	7,565
Catawba		2,539	129	974	2	6,619	91	335	10,689
Cherokee	M	594	55	399	3	1,545	45	119	2,773
Clay	M	250	21	142	0	649	32	42	1,138
Cleveland		2,422	150	885	18	6,313	30	144	10,055
Graham	M	218	29	141	0	580	31	42	1,047
Haywood	M	1,242	82	939	6	3,245	83	280	5,914
Henderson	M	1,332	141	661	2	3,466	87	365	6,065
Jackson	M	633	165	547	0	1,693	102	163	3,337
Macon	M	345	123	466	0	897	56	139	2,040
Madison	M	585	50	198	4	1,522	41	24	2,433
McDowell	MD	1,016	62	465	12	2,644	38	60	4,306
Mitchell	MD	442	69	165	9	1,152	36	20	1,900
Polk	MD	276	25	220	5	715	15	127	1,386
Rutherford	MD	1,560	97	850	6	4,048	59	489	7,121
Swain	M	303	51	217	0	863	32	65	1,536
Transylvania	M	680	28	251	1	1,769	33	139	2,915
Watauga	MD	604	146	572	6	1,572	86	183	3,187
Wilkes	M	1,797	97	999	17	4,670	28	320	7,959
Yancey	MD	341	75	179	0	890	39	22	1,554
HSA II		28,105	2,359	18,593	3,402	73,244	1,634	2,999	130,762
Alamance	M	2,218	131	2,536	2,164	5,787	73	383	13,342
Caswell	MD	611	63	553	311	1,593	46	83	3,260
Davidson		2,530	152	2,098	34	6,571	97	240	11,733
Davie	M	655	105	273	0	1,702	53	47	2,842
Forsyth	M	6,814	429	3,442	44	17,759	156	493	29,136
Guilford		7,966	992	4,799	361	20,763	922	729	36,821
Randolph		1,818	101	1,745	287	4,727	61	332	9,090
Rockingham		2,521	187	1,299	176	6,594	69	285	11,140
Stokes	M	861	42	474	0	2,248	35	68	3,736
Surry	M	1,402	94	921	18	3,652	72	227	6,399
Yadkin	M	710	62	453	7	1,850	50	112	3,262
HSA III		35,087	1,303	15,683	334	64,279	1,051	2,647	120,902
Cabarrus	M	2,050	147	1,091	23	5,358	96	330	9,132
Gaston	M	4,321	266	2,514	44	11,270	193	650	19,379
Iredell	M	2,111	118	851	6	5,501	79	148	8,838
Lincoln	M	966	47	661	0	2,514	40	171	4,408
Mecklenburg		10,189	426	8,059	146	26,505	389	720	46,672
Rowan	M	2,217	111	1,011	39	5,774	88	175	9,440
Stanly	M	11,562	70	581	26	3,001	67	176	15,503
Union	M	1,672	119	915	49	4,355	99	277	7,530
HSA IV		22,584	1,515	18,558	7,124	58,848	939	2,805	112,723
Chatham	MD	850	100	708	1,129	2,214	73	124	5,197
Durham		4,998	252	3,181	327	12,997	165	426	22,377
Franklin	M	1,155	80	614	169	3,014	110	157	5,343
Granville	MD	965	84	707	107	2,513	37	181	4,637
Johnston		2,501	178	1,798	885	6,531	91	395	12,423
Lee	MD	1,193	112	572	743	3,114	82	170	5,986
Orange	M	1,300	80	1,641	2,171	3,390	103	286	8,984
Person	MD	1,141	86	612	295	2,977	63	107	5,280
Vance	MD	1,369	88	733	138	3,559	38	188	6,155
Wake		6,412	290	7,683	1,049	16,707	86	690	32,975
Warren	M	701	165	310	111	1,832	91	80	3,367

COUNTY	*	STATE REVENUES Medicaid	STATE REVENUES Public Programs	STATE REVENUES Area Mental Health	STATE REVENUES N.C. Memorial	FEDERAL REVENUES Medicaid	FEDERAL REVENUES Public Programs	FEDERAL REVENUES Area Mental Health	STATE & FEDERAL TOTAL**
HSA V		28,916	2,263	14,043	3,885	75,617	1,636	2,444	129,475
Anson	M	1,077	101	456	75	2,810	71	86	4,721
Bladen	M	1,310	129	724	40	3,433	68	118	5,861
Brunswick	M	1,120	89	467	45	2,928	64	148	4,899
Columbus	M	2,385	168	1,219	333	6,237	94	199	10,683
Cumberland		5,822	445	2,189	585	15,238	322	20	24,717
Harnett	M	2,256	88	910	666	5,882	94	271	10,197
Hoke	M	639	58	393	42	1,675	55	74	2,976
Montgomery	M	618	57	410	112	1,618	57	77	2,963
Moore	M	1,275	187	940	190	3,324	48	178	6,168
New Hanover	M	3,178	244	1,188	192	8,314	223	377	13,787
Pender	M	791	61	254	203	2,069	75	81	3,548
Richmond	M	1,394	81	779	360	3,639	58	147	6,492
Robeson	M	3,985	224	2,509	344	10,448	193	410	18,218
Sampson	M	1,781	149	804	688	4,647	102	127	8,310
Scotland	M	1,284	184	800	10	3,354	112	131	5,935
HSA VI		34,555	3,671	12,909	1,721	90,291	2,467	2,347	149,375
Beaufort	M	1,293	63	624	19	3,365	58	54	5,524
Bertie	M	802	98	202	6	2,088	76	84	3,406
Camden	MD	150	52	69	2	392	27	6	709
Carteret	M	1,103	89	551	19	2,872	41	87	4,763
Chowan	MD	510	113	121	7	1,329	60	50	2,214
Craven	M	2,084	336	881	46	5,459	240	139	9,307
Currituck	M	188	24	157	9	493	29	14	919
Dare	M	306	41	193	2	804	30	17	1,398
Duplin	M	1,515	182	658	150	3,958	70	104	6,674
Edgecombe	M	2,469	203	777	186	6,447	144	122	10,480
Gates	MD	285	63	86	2	745	31	36	1,261
Greene	M	659	50	187	1	1,722	40	24	2,728
Halifax		2,340	255	957	187	6,139	161	110	10,264
Hertford	MD	875	165	224	43	2,293	80	93	3,809
Hyde	M	191	28	87	0	495	31	7	848
Jones	M	423	33	113	4	1,102	30	18	1,737
Lenoir		2,465	178	861	175	6,432	124	90	10,431
Martin	MD	841	131	384	39	2,202	106	33	3,772
Nash	M	2,356	200	945	286	6,144	157	148	10,358
Northampton	M	1,028	93	208	26	2,692	107	87	4,301
Onslow		1,884	207	1,114	212	4,916	117	125	8,598
Pamlico	M	457	29	124	0	1,201	38	19	1,873
Pasquotank	MD	949	253	336	39	2,503	133	30	4,296
Perquimans	MD	412	87	115	9	1,081	46	10	1,778
Pitt		3,027	219	1,197	5	7,899	175	418	13,040
Tyrrell	MD	213	21	60	2	558	17	5	881
Washington	MD	524	72	210	55	1,383	58	18	2,339
Wayne		3,045	223	739	61	7,938	98	305	12,522
Wilson	M	2,158	164	729	129	5,637	145	93	9,144

SOURCES: See explanation following Table 17 regarding programs included in each category. Figures for N.C. Memorial are detailed in Table 14.

* M denotes counties which are part of multi-county area mental health programs. D denotes counties in district health departments. In both cases, total funds per county for these respective programs have been estimated based on each county's share of population. See Table 19 for a list of district health departments and Table 20 for a list of area mental health programs

** The state and federal total also includes "special funds" reported by local health departments. These may either be federal or state revenue transfers, or in some cases will include patient fees or other collections.

Table 19

EXPENDITURES FOR PUBLIC MEDICAL PROGRAMS, FY85

DISTRICT/ COUNTY	SOURCE OF REVENUES					TOTAL
	Federal	State	County	Special	Receipts	OUTLAYS
STATE	9,186,605	13,602,084	7,365,566	3,929,455	10,760,586	44,844,296
Alamance	73,331	131,121	123,282	50,200	347,343	725,277
Alexander	46,083	51,532	73,525	4,300	40,475	215,915
Allegheny-Ashe-Watauga	168,039	285,595	72,524	37,065	577,713	1,140,936
Anson	71,417	100,923	8,100	44,017	0	224,457
Beaufort	58,104	63,354	793	46,995	8,729	177,975
Bertie	75,782	97,566	1,605	50,200	2,402	227,555
Bladen	67,889	126,604	0	39,389	143,701	379,583
Brunswick	63,868	88,994	4,387	37,775	14,281	209,305
Buncombe	163,205	335,549	76,754	80,186	48,705	704,399
Burke	63,361	87,138	5,533	12,559	3,478	172,069
Cabarrus	95,548	147,188	0	37,961	631,096	911,793
Caldwell	101,078	207,071	0	35,816	8,061	352,026
Carteret	41,411	89,240	4,738	0	4,763	140,152
Caswell-Chatham-Lee-Person	262,712	360,836	0	73,100	58,731	755,379
Catawba	90,816	129,012	98,648	0	6,258	324,734
Cherokee	45,431	55,352	1,139	12,092	3,203	117,217
Clay	31,758	21,379	7,176	2,345	1,589	64,247
Cleveland	30,436	150,084	272,957	91,842	0	545,319
Columbus	93,981	168,458	0	47,500	2,496	312,435
Craven	240,290	335,871	36,163	120,972	578,908	1,312,204
Cumberland	322,280	445,218	0	95,667	0	863,165
Currituck	28,940	23,977	0	5,071	1,149	59,137
Dare	29,904	40,910	1,100	5,000	5,427	82,341
Davidson	97,306	152,416	8,708	10,912	160,036	429,378
Davie	52,983	105,069	0	7,411	259,995	425,458
Duplin	69,680	182,150	106,657	35,983	43,224	437,694
Durham	165,372	251,843	260,439	31,326	26,602	735,582
Edgecombe	143,847	202,715	0	133,089	0	479,651
Forsyth	155,627	428,853	898,100	0	702,765	2,185,345
Franklin	110,155	80,199	0	43,276	173,877	407,507
Gaston	193,427	266,018	0	119,296	16,299	595,040
Graham	30,704	29,344	0	6,084	1,551	67,683
Granville-Vance	75,498	172,015	0	84,588	319,740	651,841
Greene	40,139	50,410	6,584	44,387	6,762	148,282
Guilford	921,574	992,094	2,312,604	289,853	311,959	4,828,084
Halifax	160,701	254,995	0	115,806	9,544	541,046
Harnett	94,177	87,835	55,742	29,273	121,159	388,186
Haywood	83,203	81,889	0	35,380	5,437	205,909
Henderson	87,157	140,844	74,607	11,689	276,854	591,151
Hertford-Gates	110,895	228,688	0	48,418	4,255	392,256
Hoke	55,448	57,690	0	38,189	0	151,327
Hyde	30,810	28,450	1,074	7,741	536	68,611
Iredell	79,485	117,730	57,886	22,977	324,729	602,807
Jackson	102,278	165,291	0	33,140	16,198	316,907
Johnston	91,242	177,901	1,546	43,775	431,219	745,683
Jones	29,666	32,648	64	14,869	250	77,499
Lenoir	123,752	177,787	0	105,915	25,676	433,130
Lincoln	39,928	46,835	170,608	8,014	7,086	272,471
Macon	56,445	123,219	148,761	14,655	0	343,080
Madison	40,783	49,705	55,740	10,257	992	157,477
Martin-Tyrrell-Washington	179,956	222,973	0	61,476	362,058	826,463
Mecklenburg	389,329	425,638	0	238,173	0	1,053,140
Montgomery	57,246	56,822	1,916	14,585	153,865	284,434
Moore	47,506	187,120	17,500	26,619	2,500	281,245
Nash	157,125	199,886	4,231	122,754	389,201	873,197
New Hanover	222,753	244,145	214,447	70,691	373,389	1,125,425
Northampton	106,771	93,061	4,922	59,719	218	264,691
Onslow	116,685	206,985	3,032	22,571	11,365	360,638
Orange	102,936	80,034	481,037	12,736	17,514	694,257
Pamlico	37,640	28,685	0	5,718	0	72,043

DISTRICT/ COUNTY	SOURCE OF REVENUES Federal	State	County	Special	Receipts	TOTAL OUTLAYS
Pasquotank-Perquimans-Camden-Chowan	265,993	504,819	38,896	105,807	100,048	1,015,563
Pender	74,830	60,625	0	13,416	31,984	180,855
Pitt	175,133	218,799	0	99,540	44,084	537,556
Randolph	61,035	100,541	0	19,516	5,211	186,303
Richmond	57,906	80,536	7,050	35,200	1,000	181,692
Robeson	192,614	223,617	241,348	105,000	4,517	767,096
Rockingham	69,343	187,310	0	9,228	4,826	270,707
Rowan	87,739	110,728	13,329	26,635	6,837	245,268
Rutherford-Polk-McDowell	113,076	183,967	0	21,764	0	318,807
Sampson	102,120	149,015	0	12,080	108,375	371,590
Scotland	112,207	183,865	0	59,622	194,866	550,560
Stanly	67,199	69,800	26,258	19,512	108,585	291,354
Stokes	34,588	42,471	59,338	7,176	191,071	334,644
Surry	71,758	94,246	27,784	13,715	1,965	209,468
Swain	32,383	51,270	742	4,903	1,379	90,677
Transylvania	32,576	28,069	24,322	13,550	2,738	101,255
Union	98,717	118,614	9,664	45,292	246,955	519,242
Wake	86,183	289,876	1,110,852	57,275	1,512,850	3,057,036
Warren	90,567	164,971	0	77,539	0	333,077
Wayne	98,154	223,468	6,534	111,186	3,390	442,732
Wilkes	28,355	96,819	918	30,541	1,543	158,176
Wilson	145,294	163,545	123,902	90,210	492,303	1,015,254
Yadkin	50,377	62,335	0	17,023	212,915	342,650
Yancey-Avery-Mitchell	112,567	217,827	0	22,326	437,783	790,503

DISTRICT HEALTH DEPARTMENTS, FY85

DISTRICT HEALTH DEPARTMENT/COUNTY	TOTAL POPULATION	COUNTY SHARE WITHIN DISTRICT	DISTRICT HEALTH DEPARTMENT/COUNTY	TOTAL POPULATION	COUNTY SHARE WITHIN DISTRICT
DISTRICT TOTAL:	68,552	100.0%	DISTRICT TOTAL:	45,294	100.0%
Alleghany	10,032	14.6%	Martin	26,567	58.7%
Ashe	23,547	34.3%	Tyrrell	4,171	9.2%
Watauga	34,973	51.0%	Washington	14,556	32.1%
DISTRICT TOTAL:	127,793	100.0%	DISTRICT TOTAL:	57,666	100.0%
Caswell	22,326	17.5%	Pasquotank	28,884	50.1%
Chatham	35,285	27.6%	Perquimans	9,905	17.2%
Lee	39,705	31.1%	Camden	5,917	10.3%
Person	30,477	23.8%	Chowan	12,960	22.5%
DISTRICT TOTAL:	75,154	100.0%	DISTRICT TOTAL:	108,622	100.0%
Granville	36,909	49.1%	Rutherford	57,032	52.5%
Vance	38,245	50.9%	Polk	14,777	13.6%
			McDowell	36,813	33.9%
DISTRICT TOTAL:	33,149	100.0%			
Hertford	23,965	72.3%	DISTRICT TOTAL:	44,900	100.0%
Gates	9,184	27.7%	Yancey	15,521	34.6%
			Avery	15,084	33.6%
			Mitchell	14,295	31.8%

SOURCES: Figures show total outlays in state FY85, by source of funds. "Special funds" reported by local health departments may include either federal or state revenue transfers, or in some cases will include patient fees or other collections. Receipts includes payments made by patients. Note that in district health departments, total outlays by county were estimated by assuming that each county received a pro rata share of funding in proportion to their share of their district's total population. Unpublished data obtained from Division of Health Services.

Table 20

EXPENDITURES FOR AREA MENTAL HEALTH PROGRAMS, FY85

AREA MENTAL HEALTH PROGRAM	ACTUAL EXPENDITURES, BY SOURCE OF FUNDS, FY85 Local	State	Federal	Total
STATE TOTAL	50,735,218	93,948,999	17,091,814	161,776,031
WESTERN REGION	19,186,633	30,118,651	6,543,930	55,849,214
Blue Ridge	949,216	2,476,278	300,255	3,725,749
Catawba	618,776	974,429	335,237	1,928,442
Cleveland	513,933	885,213	144,383	1,543,529
Foothills	1,216,753	2,625,991	341,188	4,183,932
Gaston-Lincoln	1,576,483	3,175,422	821,360	5,573,265
Mecklenburg	8,485,440	8,059,263	719,888	17,264,591
New River	1,570,292	2,367,703	758,569	4,696,564
Piedmont	867,103	2,586,637	783,071	4,236,811
Rutherford-Polk	624,419	1,070,257	616,216	2,310,892
Smoky Mountain	1,367,906	2,850,020	849,584	5,067,510
Trend	492,034	912,343	504,114	1,908,491
Tri-County	904,278	2,135,095	370,065	3,409,438
NORTH-CENTRAL	14,955,678	22,982,344	3,929,324	41,867,346
Alamance-Caswell	2,946,946	3,089,047	466,002	6,501,995
Durham	1,701,434	3,180,749	426,322	5,308,505
Forsyth-Stokes	3,297,102	3,916,447	561,005	7,774,554
Guilford	4,471,026	4,798,916	729,351	9,999,293
Orange-Person-Chatham	1,091,738	2,960,708	516,830	4,569,276
Rockingham	389,157	1,298,593	285,018	1,972,768
Surry-Yadkin	264,856	1,374,396	338,469	1,977,721
V-W-G-F	793,419	2,363,488	606,327	3,763,234
SOUTH-CENTRAL	9,151,750	25,225,663	3,538,196	37,915,609
Cumberland	1,429,245	2,188,530	20,404	3,638,179
Davidson	717,804	2,098,063	239,714	3,055,581
Johnston	781,477	1,798,223	395,012	2,974,712
Lee-Harnett	608,625	1,481,844	441,199	2,531,668
Randolph	392,479	1,744,973	331,796	2,469,248
Sandhills	714,915	2,978,880	562,427	4,256,222
Southeastern Regional	1,187,588	5,252,311	857,206	7,297,105
Wake	3,319,617	7,682,839	690,438	11,692,894
EASTERN	7,441,157	15,622,341	3,080,364	26,143,862
Albemarle	549,806	869,821	77,748	1,497,375
Duplin-Sampson	756,233	1,461,872	231,031	2,449,136
Edgecombe-Nash	753,117	1,721,415	269,824	2,744,356
Halifax	406,568	956,938	109,580	1,473,086
Lenoir	397,803	861,479	90,258	1,349,540
Neuse	834,618	1,668,119	263,260	2,765,997
Onslow	436,915	1,113,970	125,177	1,676,062
Pitt	645,196	1,197,183	417,682	2,260,061
Roanoke-Chowan	400,457	840,893	350,449	1,591,799
Southeastern	925,972	1,909,679	606,149	3,441,800
Tideland	538,884	1,365,807	117,786	2,022,477
Wayne	411,026	739,018	305,177	1,455,221
Wilson-Greene	384,562	916,147	116,243	1,416,952

AREA MENTAL HEALTH PROGRAMS, FY85

REGION	AREA PROGRAM AND COUNTY	TOTAL POPULATION	COUNTY SHARE WITHIN AREA
	STATE TOTAL:	6,229,062	
WESTERN REGION TOTAL:		2,162,105	
	BLUE RIDGE	214,222	100.0%
	Buncombe	167,299	78.1%
	Madison	17,107	8.0%
	Mitchell	14,295	6.7%
	Yancey	15,521	7.2%
	CATAWBA	112,088	100.0%
	CLEVELAND	84,549	100.0%
	FOOTHILLS	207,783	100.0%
	Alexander	26,875	12.9%
	Burke	75,539	36.4%
	Caldwell	68,556	33.0%
	McDowell	36,813	17.7%
	GASTON-LINCOLN	215,060	100.0%
	Gaston	170,282	79.2%
	Lincoln	44,798	20.8%
	MECKLENBURG	437,898	100.0%
	NEW RIVER	144,681	100.0%
	Alleghany	10,032	6.9%
	Ashe	23,547	16.3%
	Avery	15,086	10.4%
	Watauga	34,973	24.2%
	Wilkes	61,045	42.2%
	PIEDMONT	226,845	100.0%
	Cabarrus	93,133	41.2%
	Stanly	49,608	22.5%
	Union	78,104	35.4%
	RUTHERFORD-POLK	71,809	100.0%
	Polk	14,777	20.6%
	Rutherford	57,032	79.4%
	SMOKEY MOUNTAIN	144,012	100.0%
	Cherokee	20,169	14.0%
	Clay	7,152	5.0%
	Graham	7,105	4.9%
	Haywood	47,469	33.0%
	Jackson	27,635	19.2%
	Macon	23,528	16.3%
	Swain	10,954	7.6%
	TREND	91,521	100.0%
	Henderson	66,304	72.4%
	Transylvania	25,217	27.6%
	TRI-COUNTY	217,637	100.0%
	Davie	27,634	12.8%
	Iredell	86,783	39.9%
	Rowan	103,020	47.3%

REGION	AREA PROGRAM AND COUNTY	TOTAL POPULATION	COUNTY SHARE WITHIN AREA
NO. CENTRAL REGION TOTAL:		1,355,061	
	ALAMANCE-CASWELL	124,891	100.0%
	Alamance	102,475	82.1%
	Caswell	22,326	17.9%
	DURHAM	160,935	100.0%
	FORSYTH-STOKES	293,920	100.0%
	Forsyth	256,323	87.9%
	Stokes	35,597	12.1%
	GUILFORD	327,959	100.0%
	O-P-C	147,539	100.0%
	Chatham	35,285	23.9%
	Orange	81,777	55.4%
	Person	30,477	20.7%
	ROCKINGHAM	86,323	100.0%
	SURRY-YADKIN	90,203	100.0%
	Surry	60,447	67.0%
	Yadkin	29,756	33.0%
	V-W-G-F	123,381	100.0%
	Franklin	32,049	26.0%
	Granville	36,909	29.9%
	Vance	38,245	31.0%
	Warren	16,178	13.1%
SO. CENTRAL REGION TOTAL:		1,386,716	
	CUMBERLAND	255,453	100.0%
	DAVIDSON	118,179	100.0%
	JOHNSTON	74,899	100.0%
	LEE-HARNETT	102,926	100.0%
	Harnett	63,221	61.4%
	Lee	39,705	38.6%
	RANDOLPH	97,258	100.0%
	SANDHILLS	173,332	100.0%
	Anson	26,551	15.3%
	Hoke	22,884	13.2%
	Montgomery	23,826	13.7%
	Moore	54,722	31.6%
	Richmond	45,347	26.2%
	SOUTHEASTERN REGIONAL	224,467	100.0%
	Bladen	30,932	13.8%
	Columbus	52,096	23.2%
	Robeson	107,243	47.8%
	Scotland	34,196	15.2%
	WAKE	340,202	100.0%

REGION	AREA PROGRAM AND COUNTY	TOTAL POPULATION	COUNTY SHARE WITHIN AREA
EASTERN REGION TOTAL:		1,325,180	
	ALBEMARLE	74,808	100.0%
	Camden	5,917	7.9%
	Currituck	13,519	18.1%
	Dare	16,583	22.2%
	Pasquotank	28,864	38.6%
	Perquimans	9,905	13.2%
	DUPLIN-SAMPSON	92,119	100.0%
	Duplin	41,483	45.0%
	Sampson	50,636	55.0%
	EDGECOMBE-NASH	129,241	100.0%
	Edgecombe	56,329	45.1%
	Nash	70,912	54.9%
	HALIFAX	56,222	100.0%
	LENOIR	61,265	100.0%
	NEUSE	145,749	100.0%
	Carteret	48,162	33.0%
	Craven	76,955	52.8%
	Jones	9,647	6.8%
	Pamlico	10,792	7.4%
	ONSLOW	121,891	100.0%
	PITT	97,164	100.0%
	ROANOKE-CHOWAN	89,952	100.0%
	Bertie	21,590	24.0%
	Chowan	12,960	14.4%
	Gates	9,184	10.2%
	Hertford	23,965	26.6%
	Northampton	22,253	24.7%
	SOUTHEASTERN	180,951	100.0%
	Brunswick	44,272	24.5%
	New Hanover	112,565	62.2%
	Pender	24,114	13.3%
	TIDELAND	94,475	100.0%
	Beaufort	43,168	45.7%
	Hyde	6,013	6.4%
	Martin	26,567	28.1%
	Tyrrell	4,171	4.4%
	Washington	14,556	15.4%
	WAYNE	99,283	100.0%
	WILSON-GREENE	82,059	100.0%
	Greene	16,757	20.4%
	Wilson	65,301	79.6%

SOURCES: Note that in each area, total outlays by county were estimated by assuming that each county received a pro rata share of funding in proportion to their share of their area's total population. unpublished data obtained from Division of Mental Health, Mental Retardation and Substance Abuse.